Department of HUMAN SERVICES

# Claim for Targeted Medical Care

(If handwritten, use blue or black ink only. **Accuracy** is important.)

This form can only be used by **Individual Consumer-Directed Attendant Care (I-CDAC)** providers.

## Member Information

| 1. Member ID Number | 2. Member Date of Birth | 3. Member Name | |
|---|---|---|---|
| 4. Member Street Address | 5. City | 6. State | 7. Zip |

## Provider Information

| 8. NPI/Atypical NPI Provider Number | | 9. Provider Name | |
|---|---|---|---|
| 10. Provider Address | | 11. City | 12. State |
| 13. Zip | 14. Phone | 15. Tax ID/Social Security Number (SSN)* | |

*** Required field. In lieu of full SSN, providers may submit the last 4 digits of the SSN.**

## Other Information

| 16. Client Participation Amount | 17. Authorization No. (if applicable) | 18. Corrected Claim ☐ YES ☐ NO | 19. Original Claim No. |
|---|---|---|---|

## Services

| 20. Procedure Code | 21. Modifier | 22. Diagnosis Code | 23. Place of Service | 24. First Date | 25. Last Date | 26. Units | 27. Total Line Charge |
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| | | | | | 28. Total Claim Charges | | |

## Authorized Signature

| *I certify that the statements on the back apply to this bill and are made a part of it.* | Provider Signature | Date |
|---|---|---|

# Provider Certification

I hereby agree:

- To keep such records as are necessary to disclose fully the extent of services provided to members of the Iowa Medicaid Program, as specific in the Provider Manual and the Iowa Administrative Code.
- To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee, or Health and Human Services may request.
- To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.
- To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

- The services shown on the front of this form were rendered to the member and were medically indicated and necessary for the health of the member.
- The charges for these services are just, unpaid, actually due according to law and program policy, and not in excess of regular fees.
- The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements or documents or concealment of a material fact, may be prosecuted under applicable federal or state laws.

| PLACE OF SERVICE CODES | |
|---|---|
| 12 Home | 99 Other |

Submit the completed form to the member's Managed Care Organization (MCO) or to the Iowa Medicaid Enterprise (IME) if the member is on Fee-for-Service.

Fee-for-Service members: Complete claim form instructions and a printable version of this form are available on the DHS web page at https://dhs.iowa.gov/ime/Providers/claims-and-billing/ClaimsPage.

Amerigroup Iowa Inc. members:

- Claims billing address: Amerigroup Iowa, Inc., PO Box 61010, Virginia Beach, VA 23466
- Provider portal/website: https://providers.amerigroup.com/ia/Pages/ia.aspx
- Provider services: 1-800-454-3730

Iowa Total Care members:

- Claims billing address: Iowa Total Care, Attn Claims Dept; PO Box 8030, Farmington MO 63640
- Provider portal/website: https://provider.iowatotalcare.com
- Provider Services: 1-833-404-1061