REQUEST TO CONTRACT FOR SERVICES

Iowa Total Care (ITC) requests the following information for the inclusion of your entity into the Medicaid ITC network. All information is needed in its entirety in order to move forward with a contract for signature.

Please attach a copy of your signed and dated W9 (REQUIRED). If multiple providers and/or multiple locations provide services, please attach a roster of this information along with this form.

Legal Business Name (as it appears on your entity's W9):
_____

☐ New Contract ☐ Amendment to an existing contract

Iowa Medicaid Provider Type: _____

Iowa Medicaid Provider Type Number: _____

CMS Medicare Provider Number (if applicable): _____

Group (Provider) NPI(s): _____

Group Provider Tax identification Number(s): _____

Notification Address (where you want health plan information sent):

Attention: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Contact Name for Contracting: _____

Direct Phone Number: _____

Email where contract can be sent: _____

Comments: _____

_____

Please return this form and any supplemental information that you can provide by fax to attention of Iowa Total Care Network Development and Contracting at **833-208-1397.

If you have any questions or require additional assistance and information, contact NetworkManagement@IowaTotalCare.com or call **833-404-1061**.