1080 Jordan Creek Parkway
Suite 100 South
West Des Moines, IA 50266

NOTICE OF PAYMENT SUSPENSION
VIA CERTIFIED MAIL

[Date]
[Provider Name]
[Address]
[City, State Zip]

Dear [Provider First and Last Name],

Iowa Total Care (ITC) was notified on [Date] that you were placed on a payment suspension by the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME) effective [Date]. This payment suspension applies to all Medicaid claims or services provided by you.

Pursuant to the obligations set forth in 42 C.F.R. § 455.23 all Medicaid payments for you are suspended and ITC will maintain the payment suspension for the durational period set forth in 42 C.F.R. § 455.23(c). The scope of this payment suspension prevents you from submitting claims for payment and ITC will withhold payment in accordance with 42 C.F.R. § 455.23.

You have the right to appeal this decision. Please refer to the sanction letter sent to you by IME for instructions regarding your appeal rights and procedures.

Sincerely,

[Insert Name]
Provider Network

CC: Provider File