IOWA Health and Human Services

Request for Payment

Purpose: Payment of claims to non-enrolled providers.

Rendering Provider Information:

Name of Rendering Provider:	
National Provider Identifier (NPI):	
Date of Service:	
Social Security Number (SSN):	Date of Birth:
License number (please attach a copy):	Drug Enforcement Agency (DEA) Number:
Are you currently enrolled in another state's Medicaid/CHIP program? (Please list the state)	
Service Address:	
City:	State:
Zip Code:	Telephone:
Email Address:	

Billing Data:

Name or DBA Name:
National Provider Identifier (NPI):
Tax ID (for billing entity):

Mailing Address (if different than service address):	
City:	State:
Zip code:	
Pay to Address:	
City:	State:
Zip code:	
The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate and complete and that the provider has read this entire form before signing. The provider also understands penalties for falsifying information may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal and/or state law. By signing the form, you agree to adhere to Medicaid's laws and regulations & program instructions.	

Person Completing This Form:

Name:	Title:
Authorized Official Print Name:	
Authorized Official Signature:	
Date:	
Email Address:	

***By typing my name, I am electronically signing this document in accordance with Iowa Code Chapter 554D.**

Please send the completed request for payment and all applicable attachments to:

Iowa Medicaid, Attn: Provider Enrollment
PO Box 36450
Des Moines, Iowa 50315
Or email to: IMEProviderEnrollment@dhs.state.ia.us

Fax: 515-725-1155