Healthcare Provider and Facility Enrollment for Iowa Care for Yourself Program

* Required

Form Submission

1. First and Last Name of Person filling out this form *

2. Position Title *

3. Phone Number *

4. Email *

Please enter an email

5. Is this a... *

- ◯ New Care for Yourself Facility
- ◯ Update

Facility Assocation with Service Entity

6. Is your Facility associated with an entity we have a Service Entity Agreement with? *

- ◯ Yes
- ◯ No
- ◯ I am not sure

Service Entity

8. Which Service Entity is this Facility Associated With?

- ◯ Insert Service Facility Options Here. (Name, Tax ID# and Expiration Date)
- ◯ None

Facility Information

This form is for one facility, if you have multiple facilities, please fill out multiple forms. Please complete based on the location where services will be performed using the official name.

9. Service Facility Name *

(Needs to match box 32 of HCFA 1500)

10. Service Facility Physical Address *

Number/Street Name/City/State/Zip Code

11. Service Facility Mailing Address *

Number/Street Name (or PO Box)/City/State/Zip Code

12. County Facility is located in *

13. Please check types that apply for this facility *

- [ ] Ambulatory Service
- [ ] FQHC
- [ ] Lab/ Pathology
- [ ] Mammography/Radiology
- [ ] Pharmacy
- [ ] Other

14. Has this facility merged with or been bought from a different facility within the last 6 years? *

- ◯ Yes
- ◯ No

Previous Facility Information

15. Previous facility name *

16. Previous Tax ID # *

17. Previous Facility address *

Number/Street Name/City/State/Zip Code

Additional Contact for Facility

18. Are you the best contact person for this Facility? *

- ◯ Yes
- ◯ Yes, but I want to add a secondary person
- ◯ No

Facility Contact Information

19. Facility Contact Person Name *

20. Facility Contact Person Phone Number *

21. Facility Contact Person Email *

22. Facility Contact Person Position Title *

NPI #1

23. Please enter the first NPI number associated with this facility *

(Box 33A of HCFA 1500). If possible, one clinic/facility NPI number should be used for all claims; use of individual provider NPI numbers should be avoided. If this is not possible, please click yes to the question below and enter additional NPI numbers.

24. Do you have additional NPI numbers to add for this facility? *

- ◯ No
- ◯ Yes

NPI #2

25. Please enter the second NPI number associated with this facility *

(Box 33A of HCFA 1500)

26. Do you have additional NPI numbers to add for this facility? *

- ◯ No
- ◯ Yes

NPI #3

27. Please enter the third NPI number associated with this facility *

(Box 33A of HCFA 1500)

28. Do you have additional NPI numbers to add for this facility? *

- ◯ No
- ◯ Yes

NPI #4

29. Please enter the fourth NPI number associated with this facility *

(Box 33A of HCFA 1500)

30. Do you have additional NPI numbers to add for this facility? *

- ◯ No
- ◯ Yes

NPI #5

31. Please enter the fifth NPI number associated with this facility *

(Box 33A of HCFA 1500)

32. Do you have additional NPI numbers to add for this facility? *

- ◯ No
- ◯ Yes

NPI #6

If you have more than 5 NPI numbers to submit you will need to submit a new form after you complete this form.

33. Please enter the sixth NPI number associated with this facility *

(Box 33A of HCFA 1500)

Services this Facility Provide

34. Does this facility provide....

- ◯ Pap cytology, HPV screening, Breast Biopsy, any other services that require a CLIA certificate
- ◯ None of these

CLIA

A copy of each facility's Clinical Laboratory Improvement Amendments (CLIA) Certificate is required before this form will be considered valid. A copy of a VALID CLIA is required to be provided to the Iowa Care for Yourself Program when it expires, is updated, etc.

35. Do you have a CLIA for this Facility? *

- ◯ Yes
- ◯ No

CLIA Information

Please send the CLIA(s) to CareForYourself@hhs.iowa.gov

36. I acknowledge I will send the CLIA(s) to CareForYourself@hhs.iowa.gov today *

- ◯ Yes

Lack of CLIA

A copy of the facility's Clinical Laboratory Improvement Amendments (CLIA) Certificate is required before this form will be considered valid.

37. Please provide information on when you will have a CLIA *

Additional Information

38. Do you have additional information, comments or questions you would like to submit?

39. Are you willing to answer additional optional questions for us about the Iowa Care for Yourself program? *

- ◯ Yes
- ◯ No