IOWA MEDICAID
LONG TERM CARE CLAIM

FOR MONTH OF :

PROCESSING DATE:

IME
P.O. BOX 150001
Des Moines, IA 50315

PROVIDER I.D. NUMBER:

PAGE NUMBER:

	1. Medicaid I.D. #		2. Name: Last		First		MI	3. L.O.C.	4. Termination		5. Patient Acct. #			6. Medicare Coverage								
1	7. Facility Admit Date		8. Facility Disc Date		9. First D.O.S.		10. Last D.O.S.	11.	12. Per Diem Rate		13. # Days			14. Amount								
	15. Leave Days/Visit	16. Leave Days/Hosp.	17. Leave Days/Non-Cov.	18. 3rd Party Source				19. 3rd Party Amount	20. 3rd Party Source				21. 3rd Party Amount	22. Net Amount								
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IMPORTANT

READ CERTIFICATION STATEMENT ON THE REVERSE SIDE
THE PERSON WHOSE SIGNATURE APPEARS BELOW CERTIFIES THAT HE/SHE IS AUTHORIZED TO SIGN THIS INVOICE AND THAT HE/SHE HAS READ AND WILL COMPLY WITH ALL OF THE TERMS AND CONDITIONS WHICH ARE CONTAINED IN THE CERTIFICATION STATEMENT WHICH APPEARS ON THE REVERSE SIDE OF THIS INVOICE.

TOTAL
THIS PAGE

SIGNATURE/INSTITUTIONAL REPRESENTATIVE _____ DATE _____

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX Medical Assistance (Medicaid) program specified in the provider manual and the Iowa Administrative Code and to furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services or its designee may request. I further agree 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.

SIGNATURE OF AUTHORIZED REPRESENTATIVE: I certify that the services shown on the reverse side were rendered to the patient and medically indicated and necessary to the health of the patient, the charges for such service are just, unpaid and actually due according to law and program policy and not in excess of regular fees, the information provided on the reverse side of this claim is true, accurate and complete.

I agree to comply with the provisions or the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

IME
P.O. BOX 150001
Des Moines, IA 50315

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