Iowa Department of Human Services

Explanation of Medicaid Benefits

Iowa Medicaid Program
Under Title XIX of the Social Security Act

THIS IS NOT A BILL **THIS IS NOT A BILL**

RECIPIENT I.D. COUNTY PROGRAM EOMB DATE

Mail this form in the self-addressed envelope provided. No stamp is necessary.

PROVIDER OF SERVICES	DESCRIPTION OF SERVICES	DATE OF SERVICE	MEDICAID PAYMENT	FOR STATE USE ONLY

Instructions

Above is a list of medical services which have been paid recently by the Iowa Medicaid program on your behalf. After reading the above list of services, please mark an "x" after the following statements which apply to you:

Your response will not affect your Medicaid eligibility.

1. I received all services listed..... ☐
2. In my opinion, some of the services were not needed..... ☐
3. In my opinion, there was waste or misuse of services, equipment, or supplies..... ☐

If you have marked an "x" in number 2 and/or number 3, please explain in the space below:

Explanation:

_____

_____

_____

Signature	Date	Telephone