REVENUE COLLECTIONS
P.O.BOX 36446
DES MOINES, IA 50315

{Member Name}
{Address Line 1}{Address Line 2}
{City}, {State} {Zip}

Iowa Medicaid
Iowa HHS

{Member Name}
{Address Line 1}
{Address Line 2}
{City}, {State} {Zip}

Reference Number: {DCN}

First Request
Accident or Injury Request for Information

{Current Date}

Dear {Member Name}:

Iowa Medicaid received a claim for treatment for an accident or injury. We need the information requested on the back of this form to see if somebody else should have paid for the treatment.

A parent or legal guardian should complete and sign the form for a child under the age of 18 or call Iowa Medicaid Member Services at **1-800-338-8366** from 8 a.m. to 5 p.m. Monday through Friday to complete the information over the phone. In Des Moines, call **515-256-4606**. To better assist you, please have the above reference number and all the requested information available when you call.

Please respond by: <<DueDate>>. If you do not provide the requested information, your Medicaid benefits may be affected.

If you prefer to return a written copy of the form, use one of the options below:

Email: RevcoLLLien@dhs.state.ia.us

Fax: 515-725-1352

Mail: Iowa Medicaid
Revenue Collections
PO Box 36446
Des Moines, IA 50315

Phone: Member Services
1-800-338-8366
Or locally in the Des Moines area **515-256-4606**
Monday through Friday, 8:00 am to 5:00 pm

Para solicitar este documento en español, comuníquese con Servicios a los Miembros al teléfono 1-800-388-8366, de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

Iowa Medicaid
Iowa HHS

Turn Page Over

Return this information to Iowa Medicaid by **{Date Due}**

{Member Name}, {State ID}

Date of Treatment: {Date of Service} Reference Number: {DCN}
Provider's Name: {Prov Name}

Was the treatment a result of an accident or injury? ☐ Yes ☐ No
If no, sign, date, and return this form.
If yes, did the accident or injury happen on {Date of Service}? ☐ Yes ☐ No

If no, please tell us the correct date of the accident or injury. ____/____/_____
(mm/dd/yyyy)

Tell us what happened and what the injuries were. If more space is needed, attach a separate sheet of paper.

Has a lawyer been hired? ☐ Yes ☐ No If yes, complete this section.

Name of Lawyer		Phone Number
Address		
City	State	ZIP Code

Was a claim filed with an insurance company? ☐ Yes ☐ No If yes, complete this section.

Insurance Company Name		Contact Name
Address		
City	State	ZIP Code
Phone Number		Claim Number
Policy Holder Name		Policy Number

Sign, date, and return the completed form using the instructions on the front side.

Signature		Date
Print name		Relationship to member
Home Phone Number	Cell Phone Number	