Iowa Medicaid
Iowa HHS

<<NAME>>
<<ADDRESS>>
<<ADDRESS>>
<<CITY>>, <<STATE>> <<ZIPCODE>>

Reference Number: <<<<<>>>>>

Other Insurance Request

<<Date>>

Dear <<NAME>>,

Iowa Medicaid received a claim indicating <<First Name Last Name>> may have other insurance. We need the information requested on the back of this letter. It will help us determine if the other insurance company should pay before Iowa Medicaid.

To provide this information over the phone, call Iowa Medicaid Member Services 8 a.m. to 5 p.m. Monday through Friday at **1-800-338-8366**. In Des Moines, call **515-256-4606**. To better assist you, please have the above reference number and all of the requested information available when you call.

Please respond by: <<DueDate>>.

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

Email:	Revcol@dhs.state.ia.us
Fax:	515-725-1352
Mail:	Iowa Medicaid Revenue Collections PO Box 36475 Des Moines, IA 50315

A parent or legal guardian should call or complete and sign the form for a child under the age of 18.

Para solicitar este documento en español, comuníquese con Servicios a los Miembros al teléfono 1-800-338-8366, de lunes a viernes desde las 8 a.m. hasta las 5 p.m.

Turn Page Over ⇨

Return this information to Iowa Medicaid by <<DueDate>> **Reference Number**: <<<<<>>>>>

Member Name: <<First Name Last Name>>, State ID Number: <<Medicaid ID>>

Medical coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Prescription coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Dental coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Vison coverage ☐ Yes ☐ No If yes, complete this section.

Policy Holder's (PH) Name		Relationship to <<firstname>>
PH SSN	PH Date of Birth mm/dd/yyyy	PH Employer
Insurance Company Name	Insurance Policy Number	Insurance Company Phone Number

Is there anyone else in the family that is covered by the same policies? ☐ Yes ☐ No

If yes, provide their Medicaid #, name, and mark all the policies they have.

Medicaid #	First and Last Name	Medical	Rx	Dental	Vision

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

Signature		Date
Print Name		Relationship to <<firstname>>
Home Phone Number	Cell Phone Number	