Iowa Department of Human Services

AUTHORIZATION FOR EXAMINATION AND CLAIM FOR PAYMENT

From:	Date
	Examinee Name
	Address
To:	Case No.
	Purpose: ☐ Incapacity ☐ Disability

You are hereby authorized to make examination of the named applicant for or recipient of assistance.

You may charge not more than your usual and customary fee for the examination. However, payment for services will be made according to what an Iowa Medicaid provider would receive. If it is necessary because of the applicant's health condition to perform the examination in the home, and travel outside the city limits is involved, mileage at the usual and customary rate, one way, may also be charged.

Charges for diagnostic procedures involved in the examination, based on your usual and customary fee, may be approved when necessary. The procedure number for each diagnostic procedure performed (CPT or code from optometrist's manual) must be entered.

Note: Payment for services other than the examination may not be approved until eligibility for assistance has been established.

Please complete the Claim Section and return the first three copies of this form to the County Department of Human Services together with the completed copy of the attached medical report.

County Director ______________________________

Claim for payment is hereby made for services rendered:

DATE	PROCEDURE CODE	BRIEF DESCRIPTION OF SERVICE	CHARGES	LEAVE BLANK
		Total Charges		

CLAIMANT'S CERTIFICATION

I certify that the items for which payment is claimed were furnished for state business under the authority of the law and that the charges are reasonable, proper, and correct, and no part of this claim has been paid.

CLAIMANT'S SIGNATURE	TITLE	DATE

THE FOLLOWING FIELDS ARE FOR STATE ACCOUNTING USE ONLY

Doc Type (PO or PV)	Doc Number	Doc Date	Acctg Prd	Budget FY	Action New/Mod	PO Ship Instr	PV Type	Int Ind	Int Seller Fund	Int Seller Agcy
PV					E		1			

Vendor Code	Addr Override	F/A Indicator	EFT Ind	Text-PO's Only (Y/N)	Text (PO's Only)

Ref Doc Type	Ref Doc Number	Ref Doc Line	Com Ln	Vend Invoice #	Commodity Code	GS Contract

Line	Fund	Agcy	Org	Sub Org	Actv	Rsrc	Sub Rsrc	Func	Objt	Sub Objt	Job Number	Rep Cat	Quantity / Units	I/D	Description	Amount	I/D	P/F
01																		
02																		
03																		
04																		
05																		
06																		
07																		

Paid Date __________________ **Warrant #** **Document Total**

Audited By

Calculate!