IOWA DEPARTMENT OF HUMAN SERVICES
OFFICE OF ADMINISTRATIVE SERVICES
ADMINISTRATIVE STUDIES SECTION QUALITY CONTROL

MEDICAID ELIGIBILITY
FACE SHEET

COUNTY _____ REGION _____ REVIEW NO. _____ DATE _____

A. IDENTIFYING INFORMATION

1. Recipient Name
2. Recipient ID No.
3. Case Name (if differs) _____
4. Address
5. Telephone No. _____
6. Directions to Locate _____

B. CLAIM INFORMATION

1. Month and Year Paid
2. Period of Service
3. Amount of Paid Claim $
4. Claim Number
5. Vendor Number
6. Vendor Name
7. Vendor Address

C. ELIGIBILITY HISTORY

1. Local Agency _____
2. Date of Most Recent Opening _____
3. Date of Most Recent Action Before Service Period _____
4. Type of Action _____
5. Prior Address _____
6. Date of Move _____

D. REVIEW PROCESS

1. Date Assigned _____
2. Date Case Record Read _____
3. Date of Recipient Interview _____
4. Date Review Completed _____
5. Reviewer _____
6. Supervisor _____
7. FORM COMPLETED FOR;
   - FIP RELATED RECIPIENT ☐
   - SSI RELATED RECIPIENT ☐
   - NEEDY INDIVIDUAL UNDER 21 ☐

E. MEMBERS OF THE RECIPIENT'S HOUSEHOLD

	Name	Birthdate	Relationship or Significance	Social Security Number	Medicaid Recipient (✓ or *)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

F. SIGNIFICANT PERSONS NOT IN RECIPIENTS HOUSEHOLD

	Name	Age	Relationship or Significance	Social Security No.	Address
1.					
2.					
3.					
4.					

G. REVIEW FINDINGS

1. FINDING (Check One):
   - Eligible ☐
   - Ineligible (during part or all of service period) ☐
   - Recipient Liability Understated ☐
   - Recipient Liability Overstated ☐
2. Number of Errors _____
3. Dollar Amount of Errors $ _____