Iowa Department of Human Services

Verification of Paid Medical Bills

To Medical Provider: The person listed below has been approved for Medicaid and is entitled to direct reimbursement for Medicaid covered services paid for in the time period specified in Section II, **Potentially Eligible Dates for Direct Reimbursement**. Your assistance is needed to obtain information about these bills in order to reimburse. See the reverse side for instructions for completing this form. The form can be returned to the recipient or mailed to the county office listed below.

To County Agency: General Relief agencies may also receive direct reimbursement for Medicaid covered services paid for a Medicaid approved member for bills paid for in the time period specified in Section II, **Potentially Eligible Dates for Direct Reimbursement**.

Iowa Department of Human Services _____ County DHS, _____ Iowa, _____ Zip

Section I. Member Information (Completed by DHS or county agency)

Patient's Name (if other than recipient)	Case Number	Patient Name (if different from case name)	
Address	City	State	Zip

Section II. Eligibility Information (Completed by DHS)

1. Date initial application was filed with either DHS or SSA	mo.	day	year
2. Date initial application was denied	mo.	day	year
3. Date on DHS Notice of Decision that approved Medicaid	mo.	day	year
4. Date of Medicare eligibility	mo.	day	year

Potentially Eligible Dates for Direct Reimbursement

Services must have been received on or after _____ (enter Medicaid beginning date, include the three retro months if approved for retro) and before _____. (Enter NOD date from #3 above.)
(month/day/year)

Client (or county) must have paid for service on or after _____ and before _____.
(enter denial date from #2 above) (enter NOD date from #3 above)

Signature of IM Worker Completing Section II	Date

Section III. Payment Information (Completed by client or county agency)

If County Claims Reimbursement Name County Relief Agency		County Vendor Number or Federal ID Number	
Address	City	State	Zip

If Client Claims Reimbursement
Authorization for release of information: I authorize release of the following information to the Department of Human Services.

Client Signature	Social Security Number	Date

Section IV. (Completed by provider of service or county agency) Providers complete A-F only. County Assistance Agency completes A-G. Enter the information about bills for Medicaid covered services received in the time period identified in Section II.
Note: Providers, when completing this form DO NOT include:
1. Charges for services you will now be submitting claims to Medicaid for payment. 2. Amount paid for by insurance.
3. Amounts paid by for the client if you are reimbursing the client and will then be submitting a claim to Medicaid for payment.

A Date of Service	**B** Description of Service	**C** Procedure Code	**D** Amount Billed	**E** Date of Payment by Member or Co.	**F** Amount Paid by Member or Co.	**G** (Relief Agency use only) IAR Assigned Bill Y or N	**H** (DHS use only) Amount Approved

Signature of Provider or County Relief Agency and Title	Company Name	Type of Provider	Date	Total

Section V. (Completed by Iowa Medicaid Enterprise)
Eligibility date for unassigned bills from: _____ to: _____ amount: _____
Eligibility dates for assigned bills from: _____ to: _____ amount: _____

Signature of reviewer	Date

Instructions for Completion

Section I. Identifying information for the member for whom reimbursement is being requested.

Section II. Information provided by the income maintenance worker which confirms that the member attained Medicaid eligibility through the appeal process and verifies the dates of eligibility for reimbursement, including the three month retroactive months if applicable. The IM worker completing this section is required to sign and date form as indicated.

Section III. This section is completed by either the member or the county relief agency, depending on who is seeking reimbursement. When the county agency is requesting reimbursement, the county must provide either their vendor number as assigned by the state or, if they do not have a vendor number, they must provide their federal ID number in order to receive payment.

When the member is requesting reimbursement, the member must sign and date the form where indicated to authorize the release of information regarding their medical bills. When the member is requesting reimbursement, the member must provide their social security number in order to receive payment.

Section IV. If the member paid the medical bills, the medical provider completes this form for the member. If there is more than one medical provider, each provider must complete a separate form. If additional space is required, additional copies of the form may be used.

If a county agency paid bills on the recipient's behalf, the county agency completes this section. The county agency shall attach copies of invoices for verification of amounts and dates. The county agency will be reimbursed directly for such bills.

A. ***Date of Service.*** This should be the date on which the service was rendered. If a period of institutional care is involved (such as in a hospital or nursing home) inclusive dates should be shown.

B. ***Description of Service.*** Enter the type of service performed on that date, e.g., office visit, hospital visit, type of equipment dispensed. For prescribed drugs give drug name, form, strength, and amount dispensed.

C. ***Procedure Code.*** Give the procedure code number from the applicable Medicaid provider manual. Medical providers can provide the code number to county agencies.

D. ***Amount Billed.*** Provider enters the amount you billed the client or the county agency enters the amount your agency paid for this service.

E. ***Date of Payment by Member or Co.*** Provider enters the date you received payment for this service from the client or county agency enter the date payment was made for the service.

F. ***Amount Paid by Member or Co.*** Provider enters for each item, the amount paid to you by the member that has not and will not be billed to Medicaid or other insurance of the county agency enters the amount your agency paid for the service.

The provider should sign the form with name and title, enter the business name and provider type (doctor, dentist, etc.) and the date. If a county relief agency is claiming reimbursement or is furnishing this information for the member to claim reimbursement and has completed Section IV. from its records, the director of the agency or the director's designee shall sign. The form shall be submitted to the local Department of Human Services office.

G. County Assistance Agency shall enter 'Y' if bill was assigned by the medical provider to the county agency or 'N' if the bill was not assigned.

Section V. Completed by Iowa Medicaid Enterprise showing approved date for reimbursement and the amount allowed. A copy will be returned to the recipient or the county relief agency.