

MEDICAID COUNTY BILLING REMITTANCE:  
 HCBS/MR WAIVER SERVICES

ENCLOSED YOU WILL FIND A DETAILED BILLING FOR THE COUNTY'S SHARE OF THE COST OF MEDICAID ENHANCED SERVICES. THE TOTAL AMOUNT YOUR COUNTY OWES IS LISTED ON THE FINAL PAGE OF THE BILLING STATEMENT AND LISTED BELOW. PLEASE COMPLETE THIS FORM AND RETURN IT WITH YOUR PAYMENT. ANY AMOUNTS BEING DISPUTED MUST BE REPORTED ON THIS FORM IN ORDER FOR YOUR DISPUTE TO BE RESOLVED.

COUNTY NAME: XXXXXXXXX INVOICE NUMBER: 00000000 BILLING DATE: 00/00/00 TOTAL AMOUNT FROM DETAILED BILLING: \$0.00

CONTACT PERSON: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

CONSUMER NAME	STATE ID #	DATES OF SERVICE	AMOUNT BILLED	AMOUNT PAID	REASON FOR NONPAYMENT
TOTALS:					

ALL PAYMENTS SHOULD BE MADE TO THE IOWA DEPARTMENT OF HUMAN SERVICES AT THE ADDRESS BELOW:

DHS CASHIER  
 1305 E WALNUT ST  
 HOOVER BUILDING 1ST FL  
 DES MOINES IA 50319-0114

Iowa Department of Human Services  
Intellectual Disability Waiver – Medicaid

Payor Name:  
Invoice #:  
Invoice Date:

Recipient Name	State ID	First Date	Last Date	Amount Due
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____				
Total				

All payments should be made to: Department of Human Services

Mall Payments to: Department of Human Services, Cashier's Office  
Room 14, First Floor  
Hoover Building  
Des Moines, IA 50309

Thanks you for your cooperation!

Please contact Nancy Foote (515) 281-4195 with questions concerning these billings