MEDICAID BILLING REMITTANCE

[provider]

Provider NPI/Id: [ ] Invoice # [ ] Date [ ]

[provider]

Section 1: The provider's share of the cost of the [provider] services. For the month of [month and year], your agency received $[amount]. The total amount owed is $[amount] [For AEA only: at 84% of the total is $(amount)]. This form must accompany payment for proper crediting.

All payments should be made to the Iowa Department of Education at the following address:

Attn: Tana Mullen
Iowa Department of Education
Grimes Bldg., Third Floor
400 E. 14th Street
Des Moines IA 50319-0146

The amount of _____ for the month of _____ is enclosed.

_____

Signature of Authorized Representative Date

_____

Agency Name

If you have questions or concerns please contact Steve Crew at steve.crew@iowa.gov or (515)281-6285. Payment is due within 30 days of the date of this notice. Thank you for your assistance and timely payment.

cc: DHS, DE