Iowa Department of Human Services

APPLICATION FOR AUTHORIZATION TO MAKE PRESUMPTIVE MEDICAID ELIGIBILITY DETERMINATIONS (BCCT)

Provider Name: ______________________________

Address: ______________________________

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Telephone: (   ) ____________________

Provider #: ____________________

1. Are you currently enrolled in Iowa's Medicaid program? ☐ Yes ☐ No

2. Are you under a contract with the Iowa Department of Public Health as lead agency for the Breast and Cervical Cancer Early Detection Program? ☐ Yes ☐ No

   If yes, for what county or counties?______________________________

3. Do you have a cooperative agreement with the Iowa Department of Public Health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself breast and cervical cancer early detection program? ☐ Yes ☐ No

Provider Signature	Date

NOTE: The provider signature must be an original signature and must be in ink.

470-3864 (Rev. 7/01)