Iowa Department of Human Services

Iowa Medicaid Provider Form Request

To order forms, please enter the quantity of each form needed. Complete your name and address in the label section, and mail to: IME, Form Requests, P.O. Box 36450, Des Moines, Iowa, 50315. Please allow 30 days for delivery.

QUANTITY	DESCRIPTION
_____	Certification Regarding Abortion (470-0836)
_____	Claim for Targeted Medical Care (470-2486)
_____	Consent for Sterilization (470-0835)
_____	Consent for Sterilization (Spanish) (470-0835S)
_____	Hearing Aid Evaluation/Selection Report (470-0828)
_____	Medicaid Prenatal Risk Assessment (470-2942)
_____	Medically Needy Expense Deletion Request (470-3931)
_____	Provider Inquiry (470-3744)
_____	Report for Enhanced Services (470-2464)
_____	Report of Examination for a Hearing Aid (470-0361)
_____	Request for Prior Authorization (470-0829)

From: Provider Number_____

Name_____

Address_____

City_____ State_____ ZIP_____