Department of Human Services

Affidavit and Agreement for Issuance of Duplicate Check

I, ________________________________ of ________________________________,
(Name) (Street & City)

County of_________________, __________, being duly sworn, depose and say that
(County Name) (State)

a check of the State of Iowa Medicaid Program, check number ___________ in the amount of

$______________ issued _____________, drawn to my order has not been received by me,
(dollar amount) (date issued)

nor do I have any knowledge as to its whereabouts.

- In consideration of the issuance and delivery to me of a new or duplicate check in like amount I hereby agree that I will promptly surrender the warrant first described should such warrant ever come into my possession, custody or control.
- I understand that any willfully false statement or representation I make may subject me to prosecution for a fraudulent practices as defined in 714.8(10) Code of Iowa.

____
(Name)

____
National Provider Identifier

____
(Date)

Please mail completed and signed form to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

This affidavit will also be considered a request to stop payment on the original check. Return this form to the above address. This form cannot be faxed.