Department of HUMAN SERVICES

[Provider Name]
[Address Line 1]
[City, Sate, Zip]

[Date]

RE: Your Claim(s) for , , . DCN #
NPI Number: [NPI Number]

Dear Provider:

The above referenced claim cannot be submitted for processing. In order for your claim to be processed, the following information must be corrected or added:

- ❑ Invalid/missing NPI number. The NPI number should be located in box 3
- ❑ The Member's state ID number is missing/invalid. The ID number should be 7 digits with a letter at the end, no spaces or dashes. Ex: 1234567A
- ❑ The print is too light/too dark to read, please use blue or black ink only
- ❑ The Provider/Member signature and/or date is missing
- ❑ The procedure code required in box 10A is missing or invalid. The procedure code should be 5 characters, a W followed by 4 numbers with no spaces or dashes.
- ❑ The Place Of Service code required in box 10B is missing or invalid. Please refer to the back of the claim form for the correct 2 digit code
- ❑ The claim should be billed with one month per line. Ina MM/DD/YY format Ex: 01/01/00-01/31/00
- ❑ Forwarded your claim to the Credit and Adjustment Unit
- ❑ Other:

Please make the above noted corrections and resubmit your claim for processing to; Iowa Medicaid Enterprise, PO Box 36450, Des Moines, IA 50315. If you have any questions, please contact the Provider Services Unit at (515) 725-1004 option 3 (locally) or (800) 338-7909 option 3.

Sincerely,

[CSR Name]

Provider Services Unit
Iowa Medicaid Enterprise