Iowa Medicaid
IOWA HHS

Re: Dispute Resolution for _____ (Period YYYYQ#)

This letter serves to confirm resolution with _____ for the period of _____.

Because of our unit-based resolution efforts, both parties agree that the attached account summary accurately reflects the rebate quarters and amount of resolution, including units/amounts resolved or adjusted.

Both parties agree to this resolution to date. However, each party understands that if any additional information arises which would cause an adjustment to these quarters, each party reserves the right to seek such adjustments.

Please confirm your agreement to this resolution of this dispute by signing this letter in the indicated space below and emailing to PBA_iarebate@changehealthcare.com. If there is a balance due, please remit payment plus any applicable interest. Credits should be applied through the normal prior quarter adjustment process.

If you need any assistance or have further questions, please contact the Iowa Medicaid Dispute Resolution Team at PBA_iarebate@changehealthcare.com or you may call 1-207-622-7153.

Agreed to and Accepted For:

STATE: IOWA

NAME & TITLE: Elizabeth Matney, Iowa Medicaid Director

SIGNATURE:

DATE: _____

LABELER: _____

NAME & TITLE: _____

SIGNATURE: _____

DATE: _____