Recoupment Request

Iowa Department of Human Services

Download this form @ http://www.ime.state.ia.us/Providers/Forms.html#DF

SECTION A: Reason recoupment; please select at least one reason.

☐ Iowa Care   ☐ Billed in Error   ☐ Other** **(please specify below)**

- **Recoupment requests will result in a retraction of an entire claim payment. A remittance advice must be attached for processing.**

- **DO NOT use this form for primary insurance payment adjustments.**

**Please specify the reason for the recoupment request:

SECTION B: This section must be completed to process the request.

- 17-Digit TCN: _____

- NPI Number: _____   Taxonomy: _____   Zip: _____

- State ID: _____   Patient Acct #: _____

Signature: _____   Date: _____

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