Department of HUMAN SERVICES

Iowa Medicaid Meals and Lodging Claim Form

This form must be completed for each trip requiring meal and/or lodging reimbursement. Claim forms with incomplete information will not be reimbursed until all required information is received. Receipts are required for all meals and lodging expenses. Reimbursement amounts are specified in the Iowa Medicaid Meals and Lodging Reimbursement Policy. Mileage is to be reported on the Mileage Reimbursement Form. Mileage is calculated as the shortest distance as calculated by MapQuest.

Member/Trip Information:

Medicaid ID:	
Trip Conf. ID #:	
Member Name:	
Phone:	
Address:	
City:	
State:	
Zip:	
Attendant Name:	

Lodging Information:

Start Date:	
End Date:	
Lodging Name:	
Phone:	
Address:	
City:	
State:	
Zip:	
Cost per Night:	

Medical Provider Information:

Name:	
Phone:	
Address:	
City:	
State:	
Zip:	

Number of Meals:

Meal	Count	Cost
Breakfast		
Lunch		
Dinner		

Member hospitalized? ☐ Yes ☐ No

Period of time? _____

Member Signature: _____ **Date:** _____

To be completed by Physician/Medical Provider:

By signing below, I verify that the Member's condition and/or treatment requires them (and attendant, if applicable) to incur additional meals and/or overnight lodging expenses.

Physician/Medical Provider Name: _____ Date: _____
(Print) (Signature)

Iowa Medicaid Provider # NPI: _____ Other: _____

I certify that the above named member's medical conditions require an attendant to accompany them during their appointments.

_____
(Signature)

Please complete and return to Access2Care, 405 SW 5th Street, Suite C, Des Moines, IA 50309-4609 or Fax to: 1-877-645-7837. If you have questions, call 1-844-521-9948 during normal business hours.