Iowa Department of Human Services

Iowa Medicaid
Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program
Provider Enrollment Application

The purpose for this type of enrollment is for non-Medicaid enrolled providers to become eligible to bill Medicaid for the cost-sharing obligations of members enrolled with HIPP or QMB. Reimbursement is limited to co-pay, co-insurance, and deductible of covered services.

To avoid delays in the enrollment process, please use this check list to ensure all required documents and supporting documentation are submitted:

- Please type or print information
- If any field is not applicable, please enter N/A
- If extra space is needed to answer any questions, please attach any additional pages
- An incomplete form may delay the approval of this application

☐ Form 470-5262, *QMB or HIPP Program Provider Enrollment Application*. **Attach a photocopy of all certifications, licenses, or accreditation documents**. Complete one for each individual professional or institutional category that is part of your business and submit to the Iowa Medicaid Enterprise.

☐ Form 470-2965, *Iowa Medicaid Provider Agreement General Terms* **(last page must be completed)**. One form per Tax ID or Social Security Number is required.

☐ Form 470-4202, *Electronic Fund Transfer (EFT) Authorization*. **Must attach voided check or bank letter**.

☐ IRS Form W-9. One form per Tax ID or Social Security Number required.

☐ Form 470-5112, *Designated Contact Person*. **Must attach copy of driver's license or state issued ID**. One form per Tax ID or Social Security Number required.

Instructions:

1. Enter the type code from the list provided.
2. Enter the licensee or "doing-business-as" name. For individuals that are part of an organization, list the individual's name.
3. Tax ID: Enter the Tax ID of the entity to which payment will be made.
4. Enter the requested effective date of the enrollment.
5. Social Security Number (SSN): Enter the nine-digit SSN for the individual in box 2. No entry is required if it is an organization.
6. Date of birth: Enter the DOB of the individual in box 2. No entry is required if it is an organization.
7. Enter the physical address of the service location. **NOTE**: Each service location must be enrolled for which medical records are stored. Make additional copies as needed to indicate more service locations.
8. Enter the phone number, fax, and email address.
9. 1099 Mailing Address: Enter the pay to address used for mailing 1099s.
10. Enter the mailing address.
11. Enter the National Provider Identifier (NPI): Enter the NPI of the individual or organization name in box 2.
12. Enter the Taxonomy code of the billing provider. **NOTE**: If the individual listed in box 2 is a member of a group, this box is not required and may be left blank.

13. (a) Enter the professional license or certification number. **NOTE**: Please attach a copy of your license/certification documents.
    (b) Enter the initial effective date.
    (c) Enter the current expiration date.
14. Enter the Drug Enforcement Agency (DEA) number. If the provider does not have a DEA number, enter N/A. If the provider is a physician, this must be entered.
15. For physicians only: Enter the primary specialty, if applicable.
16. For physicians only: Enter the secondary specialty, if applicable.
17. Check the **Yes** box if there has ever been disciplinary action against this provider's license by a licensing board in any state and attach an explanation. Check **No** if there has not been any disciplinary action.
18. Check the **Yes** box if Medicare or any state health program has ever sanctioned the provider and attach an explanation. Check **No** if there have not been sanctions.
19. Check the **Yes** box if convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid or the Title XX services program and attach an explanation. Check **No** if there have not been any convictions.
20. (a) Check **Yes** or **No** if you are enrolled in another state's Medicaid/CHIP Program
    (b) Check **Yes** or **No** if you are enrolled with Medicare

Pharmacies only

21. (a) Enter the National Council for Prescription Drug (NCPDP) number.
    (b) Acknowledgement: If you are a pharmacy located outside of the state of Iowa, check one box.

Independent Labs Only

22. Enter the 10-digit Clinical Laboratory Improvement Amendments (CLIA) certification code. Please attach a copy of your current CLIA certification. Effective date and Termination date. Group linkage information: If the individual referenced in box 2 will be linked to a group, enter the group information here. **NOTE**: If the NPI, taxonomy, and zip code provided do not match a group already enrolled in Iowa Medicaid, the application will be returned for corrections. A group application must be submitted to enroll the group.
23. Enter the organization NPI with which the individual profession is associated. This is the NPI under which payments will be made.
24. Enter the organizational Taxonomy code.
25. Enter the organizational zip code.

Print name of legal entity, signature, and date.

Master Provider Listing: Use this list to identify your provider type in box one.

- Categories in bold below are considered Moderate or High risk and subject to a pre/post enrollment site visit and other enhanced screening requirements.

Type Code	Category	Primary Certification	Additional Certification
1	General Hospital	CMS certification	License *CLIA
2	Physician MD	License	*CLIA
3	Physician DO	License	*CLIA
4	Dentist	License	
5	Podiatrist	License	
6	Optometrist	License	
7	Optician		
8	Pharmacy	License	Medicare enrollment
9	**Home Health Agency**	CMS certification	
10	**Independent Lab**	CLIA certificate	Medicare enrollment

Type Code	Category	Primary Certification	Additional Certification
11	**Ambulance**	License	
12	**Medical Supplies**	Medicare enrollment	
13	Rural Health Clinic	CMS certification	
14	ESRD	CMS certification	
15	**Physical Therapist**	License	Medicare enrollment
16	Chiropractor	License	Medicare enrollment
17	Audiologist	License	
18	Skilled Nursing Facility	DIA/CMS certification	License
19	**Rehab Agency**	CMS certification	
20	Intermediate Care Facility	DIA/CMS certification	License
21	**Community Mental Health**	Bureau of Community Services	
22	Family Planning	Dept Public Health approval	
23	Residential Care Facility	License (DIA)	
25	ICF/ID State	DIA/CMS certification	License
26	Mental Hospital	CMS certification	License
27	Community-Based ICF/ID	DIA/CMS certification	License
29	Psychologist	License	NRHSPP cert
30	Screening Center	Dept Public Health approval	
31	Hearing Aid Dealer	License	
32	Occupational Therapists	License	Medicare enrollment
34	Orthopedic Shoe Dealer		
35	Maternal Health Center	DHS approval	
36	Ambulatory Surgical Center	CMS certification	
38	Certified Nurse Midwife	License	Board cert *CLIA
39	Birthing Center	DHS approval	
40	Area Education Agency	IA Dept of Education Agreement	
41	Psych Medical Inst. Children (PMIC)	DIA license	
42	Case Manager	DHS approval	
44	CRNA	License	Board cert
45	**Hospice**	CMS certification	*CLIA
48	Clinical Social Worker	License	Medicare enrollment
49	Federal Qualified Health Center (FQHC)	CMS certification	HRSA grant
50	Nurse Practitioner	License	Board cert *CLIA
52	Nursing Facility - Mentally Ill	DIA/CMS certification	License
54	County Relief	DHS approval	
55	Lead Investigation Agency	Dept Public Health approval	
56	Local Education Agency	IA Dept of Education Agreement	
57	Early Access Service Coordinator	IA Dept of Education Agreement	
58	PACE	CMS PACE agreement	
62	Behavioral Health	License	
63	Behavioral Health Intervention Srvs (BHIS)		
64	Habilitation Services	Applicable certification/accreditation	
67	Assertive Community Treatment (ACT)	License	
69	Independent Speech Pathologist	License	
71	Health Home	TransforMED self-assessment or NCQA recognition	Health home agreement
72	Public Health Agency	Board of Health Jurisdiction letter	
76	Accountable Care Organization		ACO Agreement
99	Waiver	HCBS Application required	

Please print this section and complete for each individual professional and institutional category.

Check the box or boxes for which you are enrolling

☐ QMB Only	☐ HIPP Only

1. Type Code	**2. Licensee or DBA Name**	**3. Tax ID (for billing entity)**	
4. Requested Effective Date of Enrollment	**5. Social Security Number**	**6. Date of Birth**	
7. Primary Service Address	**City**	**State**	**Zip**
8. Primary Address and Phone Number	**Fax**	**Email**	

9. Pay to Address (used for 1099)	**City**	**State**	**Zip**
10. Mailing Address	**City**	**State**	**Zip**

11. National Provider Identifier (NPI)	**12. Taxonomy Code (if applicable)**
13a. Primary Professional License or Certification Number – **PLEASE ATTACH A COPY OF YOUR LICENSE/CERTIFICATION DOCUMENTS**	**13b. State Issued**
13c. Initial Effective Date	**13d. Current Expiration Date**
14. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.	
15. Primary Specialty* (if applicable)	**16. Secondary Specialty* (if applicable)**
17. Has there ever been disciplinary action against this provider's license by a licensing board in any state? ☐ Yes ☐ No **IF "YES," PLEASE ATTACH AN EXPLANATION**	
18. Has the provider ever been sanctioned by Medicare or any state health program? ☐ **Yes** ☐ **No** **IF "YES," PLEASE ATTACH AN EXPLANATION**	
19. Has the provider been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid, or the Title XX services program? ☐ Yes ☐ No **IF "YES," PLEASE ATTACH AN EXPLANATION**	
20a. Are you currently enrolled in another state's Medicaid/CHIP program? ☐ Yes ☐ No	**20b.** Are you currently enrolled with Medicare? ☐ Yes ☐ No

For Pharmacies Only

21a. Enter the National Council for Prescription Drug Programs (NCPDP) Number

21b. Acknowledgement for pharmacies located outside the state of Iowa: According to the Iowa Administrative Code 657-19.2(155A), a pharmacy located outside of Iowa shall apply for and obtain, pursuant to provisions of 657-8.35(155A), a nonresident pharmacy license from the board prior to providing prescription drugs, devices, or pharmacy services to an ultimate user in this state. Please complete the acknowledgement below: (Check one)

☐ **The rule listed above does not apply to the pharmacy that is applying to be a provider with the Iowa Medicaid Program.**

☐ **The rule listed above does apply to this pharmacy. Please attach a copy of the Iowa nonresident pharmacy license.**

For Independent Lab Only

22. 10-digit Clinical Laboratory Improvement Amendments (CLIA) Number

Effective Date	**Termination Date**

Payment Method Information: EFT is required when billing under a Federal Tax ID Number.
Debit card is only an option if an individual is doing business under a Social Security Number.

Group Linkage Information*
Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:

23. Organizational NPI	**24.**Organizational Taxonomy	**25.** Organization location zip

The provider certifies that the information submitted on this enrollment is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Print Name of Legal Entity

Signature of Authorized Signatory Date

Please mail this completed Provider Application and all applicable attachments to:

Iowa Medicaid Enterprise
Attn: Provider Enrollment
PO Box 36450
Des Moines, IA 50315