

## Iowa Department of Human Services

## **Wraparound Supporting Claims Detail**

Patient Name	Medicaid ID#	Date of Service	Paid Date	CPT Code	Amount Billed	Amount Paid by MCO	Amount Paid By Other Source	Claim Adjusted (Y or leave blank)	Adjusted Clain Identifier									
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470-5419 (Rev. 10/16) 2 of 22

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470-5419 (Rev. 10/16) 3 of 22

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470-5419 (Rev. 10/16) 4 of 22

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470-5419 (Rev. 10/16) 5 of 22

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470-5419 (Rev. 10/16) 6 of 22

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470-5419 (Rev. 10/16) 8 of 22

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470-5419 (Rev. 10/16) 9 of 22

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470-5419 (Rev. 10/16) 15 of 22

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470-5419 (Rev. 10/16) 20 of 22

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470-5419 (Rev. 10/16) 21 of 22

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470-5419 (Rev. 10/16) 22 of 22