Iowa Department of Human Services

Wraparound Supporting Claims Detail

Patient Name	Medicaid ID#	Date of Service	Paid Date	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	Amount Billed	Amount Paid by MCO	Amount Paid By Other Source	Claim Adjusted (Y or leave blank)	Adjusted Claim Identifier

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