Iowa Medicaid Enterprise (IME)

Provider Request to Terminate Enrollment

This form is used to request a termination. It is the provider's responsibility to ensure that their provider records are kept up to date. To avoid delays please complete all applicable fields. If extra space is needed to answer any question, please attach any additional pages.

Send the completed provider request to terminate enrollment to:

Iowa Medicaid Enterprise
Attn: Provider Enrollment
PO Box 36450
Des Moines, IA 50315
Or email to: IMEProviderEnrollment@dhs.state.ia.us

Note:
This request will be shared with all three Managed Care Organizations (MCOs), Amerigroup Iowa, Inc., Iowa Total Care, Inc., and UnitedHealthcare Plan of the River Valley, Inc. upon completion by the IME Provider Enrollment Unit.

Provider Name
Enter the provider name

National Provider Identifier (NPI) Number
Enter the NPI number

Tax Identification (ID)/Social Security Number (SSN)
Enter the federal Tax ID number or SSN for the NPI number

Taxonomy Code
Enter the taxonomy code if applicable

Requested Termination Date
This date should be the day after your last date of service is provided. All dates of services after the requested termination date will not be paid.

Location(s) Service Address
Enter the service location(s). If additional space is needed please attach additional pages. If all service locations are enrolled under the above NPI, tax ID/SSN, check the box next to all locations.

Reason for Termination
Please check all boxes that are applicable. If other, please write a brief description why you are requesting termination.

Authorized Signature, Date, and Contact Phone Number
Required

Iowa Department of Human Services

Iowa Medicaid Enterprise (IME)

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Provider Name	
NPI Number	Tax ID/SSN
Taxonomy Code (if applicable)	Requested Termination Date

Location(s): Service Address ☐ All locations

Street Address	City	State	Zip Code

Reason for Termination (Please check one):

☐ Change of ownership (Tax ID change)
☐ No longer employed with this Tax ID
☐ Retired
☐ Provider deceased
☐ License suspended
☐ Medicare disenrollment
☐ Other:_____

Authorized Signature	Date
Contact Phone Number	

I understand that any payment of claims after the requested effective date will not be paid. In the case of a retro termination request the provider is obligated to adjust or refund any payments made for dates of services after requested termination date. I certify that the information submitted on this form is accurate and complete and have read this entire form before signing.