

Iowa Medicaid – 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
Attn: Provider Enrollment
PO Box 36450
Des Moines, IA 50315
or Fax: 515-725-1155

Note:

Once our system is updated the information will be shared with the MCOs.

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 and/or SSN for individuals.

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 of why you are requesting termination.

Authorized Signature, Date, Contact Phone Number and email address

Required

Provider Request to Terminate Enrollment

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):

- | | |
|--|--|
| <input type="checkbox"/> Change of ownership (Tax ID change) | <input type="checkbox"/> No longer employed with this Tax ID |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Provider Deceased |
| <input type="checkbox"/> License suspended | <input type="checkbox"/> Medicare disenrollment |
| <input type="checkbox"/> Other: _____ | |

Authorized Signature	Date
Contact Phone Number	
Email Address:	

I understand that any payment of claims after the requested termination 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 the 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.