



Iowa Department of Human Services

## Wraparound Payment Request Access for the Iowa Medicaid Portal Access (IMPA) System

This form is for use by providers to request Wraparound Payment access on IMPA.

Organization Name	IMPA Username
Tax Identification Number *	National Provider Identification (NPI) Number *

### Contact Information of Person Completing this Form

First Name	Last Name
Telephone Number	Email

### Certification Statement and Signature

Signature and Date \*\*

**\*\* Sign this form electronically by typing your name and the date.**

Please check the statement below to express your agreement.

I am authorized to access my Organization's Wraparound Payment data.

Please grant me permission to upload documents.

**After completing this registration form, please submit the form as an email attachment by clicking on the "SUBMIT" button below.**

**SUBMIT**

For any security access inquiries, please send an email to [IMPAsupport@dhs.state.ia.us](mailto:IMPAsupport@dhs.state.ia.us).