IOWA | Health and Human Services

Case Mix Payer Change Form

Date:	Roster Year:	Quarter End Date:
Facility Name:	Facility ID: IA	
Sender Phone:	Sender Email:	MDS Contact:

Submit to: Iowa Medicaid Quality Improvement Organization, casemix@dhs.state.ia.us

THE CASE MIX PAYER CHANGE FORM IS USED ONLY FOR PAYER SOURCE COMMUNICATION

All payer source changes must be submitted within 14 days of the date the Preliminary Case Mix Roster was available in the Iowa Medicaid Portal Access (IMPA) system.

NOTE: This form should not be used for PDPM discrepancies or changes to Medicaid numbers. If the Medicaid number has been entered incorrectly in A0700 OR, the member was pending Medicaid and was approved for Medicaid with the effective date being the month or months prior to the assessment listed on the preliminary roster, you MUST modify that assessment to correct or add the Medicaid number in A0700 and successfully transmit by the cutoff date.

RESIDENT NAME	LAST 4 SOCIAL SECURITY #	PAYER CHANGE TO:	MEDICAID APPROVED DATE
Example: Jane Doe	***-**-*9999*	*Medicaid-Medicare-Other*	*3/1/2018*

This form is available on the HHS website at: hhs.iowa.gov/media/6231/download?inline=

Nursing Facility: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/nursing-facility-rates

Provider Forms: hhs.iowa.gov/programs/welcome-iowa-medicaid/provider-services/imeprovidersforms