ASSIGNMENT OF MEDICAID CLAIM

In consideration of payment of medical services listed below at the amounts requested, _____ (*provider name*), an enrolled provider in the Iowa Medicaid program, assigns to _____ (*name of county agency*) all rights to Medicaid payment for the services listed, pursuant to 441 Iowa Administrative Code 80.6(2).

Date of Service	Service	Patient	Payment Requested

Completed Medicaid claim forms for all services listed are attached.

In further consideration of payment for these services, the provider also agrees to assist _____ County in obtaining Medicaid reimbursement for them.

Provider Signature	Date

ACCEPTANCE

_____ County accepts this assignment and agrees to pay for the services listed at the amounts requested.

Signature of County Official