

**Iowa Medicaid Enterprise
Iowa Department of Human Services
Claim For Targeted Medical Care Form Instructions
(Revised 7/08)**

The table below follows the revised Claim for Targeted Medical Care by field number, field name/description, whether or not that field is required, and a brief description of the information that needs to be entered in that field, and how it needs to be entered.

Accuracy is important, please type. If handwritten please print legibly, and use only blue or black ink.

You must use the original claim form or the downloadable version available on the IME website at: <http://www.ime.state.ia.us/Providers/index.html>. To order blank forms, contact Provider Services at 1-800-338-7909 or locally (in the Des Moines area) at 515-725-1004.

If you have any questions about this information, please contact Provider Services at 1-(800)-338-7909 (Local in the Des Moines area at (515)-725-1004)

FIELD NO.	FIELD NAME/DESCRIPTION	REQUIREMENTS	INSTRUCTIONS
MEMBER INFORMATION			
1	STATE ID	REQUIRED	Enter the member's state ID found on the <i>Iowa Medicaid Eligibility Card</i> . The ID number consists of seven digits followed by a letter, i.e. 1234567A
2	MEMBER'S NAME	REQUIRED	Enter the member's last name, first name, and middle initial.
PROVIDER INFORMATION			
3	NPI PROVIDER NUMBER	REQUIRED	Enter the NPI of the provider.
4	NAME	REQUIRED	Enter the name of the provider.
5	PROVIDER ADDRESS	REQUIRED	Enter the address of the provider.
6	ZIP CODE	REQUIRED	Enter the zip code associated with the provider's address. Note: The zip code must match the zip code confirmed during NPI verification. To view the confirmed zip code visit imeservices.org
7	TAXONOMY CODE	SITUATIONAL	REQUIRED IF the NPI reported in box 3 does <u>not</u> begin with an "X." In this case, enter the taxonomy code associated with the provider. If NPI starts with "X00," leave this field blank. Note: The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code visit imeservices.org
8	OTHER INSURANCE	SITUATIONAL	REQUIRED IF the member has other insurance. Check if the member has other insurance. If no, leave blank.

9	OTHER INSURANCE DENIED	<i>SITUATIONAL</i>	<p>REQUIRED IF the member has other insurance that has denied payment. Check if the member's other insurance has denied payment.</p> <p>If no, leave blank.</p>
SERVICES			
10A	PROCEDURE CODE	REQUIRED	Enter the five-digit service code for each service being billed on the claim.
10B	*PLACE OF SERVICE	REQUIRED	Enter the two-digit place of service for each service being billed on the claim.
10C	FIRST DATE	REQUIRED	<p>Enter the first date of service for the month. Entries should be made in MM/DD/YY format.</p> <p>Note: Please wait until the month following the month that services we provided to bill the claim.</p> <p>A line can only contain services that took place in a single month. If service took place in multiple months, you must list the services of each month on separate lines.</p>
10D	LAST DATE	REQUIRED	<p>Enter the last date of service for the month. Entries should be made in MM/DD/YY format.</p> <p>Note: Please wait until the month following the month that services we provided to bill the claim.</p> <p>A line can only contain services that took place in a single month. If service took place in multiple months, you must list the services provided in each month on separate lines.</p>
10E	UNITS	REQUIRED	<p>Enter the total number of units being billed for each line.</p> <p>Note: All units should be entered using whole numbers only (i.e. "1"). Do <u>not</u> indicate partial units or anything after a decimal (i.e. "1.5").</p>
10F	TOTAL LINE CHARGE	REQUIRED	<p>Enter the total charge for each line.</p> <p>Note: The total must include both dollars and cents. If this is <u>not</u> followed, it may result in a payment different from what you were expecting.</p>
11	TOTAL CLAIM CHARGES	REQUIRED	<p>Enter the sum of the total line charges (column 10F).</p> <p>Note: The total must include both dollars and cents. If this is <u>not</u> followed, it may result in a payment different from what you were expecting.</p>
12	CLIENT PARTICIPATION AMOUNT	<i>SITUATIONAL</i>	<p>Enter the amount that the member is contributing.</p> <p>If none, leave blank.</p> <p>Note: The total must include both dollars and cents. If this is <u>not</u> followed, it may result in a payment different from what you were expecting.</p>

13	THIRD PARTY PAYMENT	<i>SITUATIONAL</i>	<p>Enter the total amount of payments paid by a third party.</p> <p>If none, leave blank.</p> <p>Note: The total must include both dollars and cents. If this is <u>not</u> followed, it may result in a payment different from what you were expecting.</p>
AUTHORIZED SIGNATURE (S)			
	PROVIDER SIGNATURE	REQUIRED	The provider must sign and date the claim.
	MEMBER/GUARDIAN SIGNATURE	<i>SITUATIONAL</i>	<p>REQUIRED IF any procedure is for Consumer Directed Attended Care (CDAC). CDAC includes any of the following procedure codes: W1265, W1266, W1267, W1268 and/or W2517. In these cases the member or the member's guardian must sign and date the claim.</p> <p>Note: If the member's guardian is signing the claim, the guardian must sign their <u>own</u> name, and indicate that they are the guardian. A guardian should <u>not</u> sign the member's name.</p>