



Iowa Department of Human Services
Revised 09/11

Instructions for Completing the Iowa Department of Human Services Iowa Medicaid
Provider Enrollment Application

- Please type or print information
- If any field is not applicable, please enter N/A
- If extra space is needed to answer any questions, please attach any additional page(s)
- An incomplete form may delay the approval of this application
- Please do not complete shaded areas

Section A: General Information: This section is completed only for Tax ID's enrolling with Iowa Medicaid for the first time.

Practice Information

1. Enter the full name of the practice as it appears on your income tax return
2. Enter the nine-digit Federal Employer Identification Number (FEIN) of the business or the Social Security Number (SSN) of the individual for which this application is being filed. Note: if you are adding an individual to an existing group, enter the FEIN of the group. Check the box to indicate which number you are listing.
3. Enter your Primary Organizational NPI. This is the NPI you will use to bill Iowa Medicaid. If you are not a "health care provider" as defined at 45 C. F.R. §160.103, please complete the Atypical Declaration Form.
4. Primary Physical Location
 - a. Enter the street number of your primary office location
 - b. Enter your suite/apartment number
 - c. Enter the state name
 - d. Enter the zip code
5. Enter the County name
6. Enter the phone number
7. Enter the fax number
8. Check the box that best matches the type of business being enrolled
 - a. Check appropriate box
 - b. 340b-The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992, which is Section 340B of the Public Health Service Act. 340B provider is able to acquire drugs through that program at significant discounted rates. Because of the discounted acquisition cost on these drugs, such are not eligible for the Medicaid drug rebate. State Medicaid programs are obligated to assure that rebates are

not claimed on these drugs. Please refer to Informational Letter 699 for more information.

9. Mailing address for Medicaid related correspondence

- a. Enter the mailing address, if it is different from the address provided in #4
- b. Enter the city name
- c. Enter the state name
- d. Enter the zip code

10. Enter the e-mail address for Medicaid related correspondence

Payment Information

11. Check one box: Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolled using a Federal Employer Identification Number (FEIN) of the business. Debit card is only an option if an individual is doing business under a Social Security Number in #2.

- a. Enter the Pay to Address- This address is used for mailing of the debit card and 1099's

12. Pharmacies Only

- a. Enter the National Association of Boards of Pharmacy (NABP) number, if you are a pharmacy
- b. For pharmacies that are located outside of the State of Iowa, select one box

13. CLIA Certification

- a. Enter the 10-digit Clinical Laboratory Improvement Amendments (CLIA) certification code. If you are providing services, which require CLIA certification, you must submit a copy of your current CLIA certification.
- b. Enter the effective date
- c. Enter the termination date

Note: if you are enrolling more than one location please attach a of the CLIA certification for each location

14. Certification

- a. Enter the printed name of the legal entity
- b. Enter the printed name and title of authorized signer
- c. The authorized signatory signs here
- d. Enter the date of the signature

Section B: Organization Data-Master Provider Listing

Page 3 is a listing of Iowa Medicaid provider types. Use this list to identify your provider type code and to determine whether additional certifications are required for enrollment. Enter the type code in Box 16 of the application. Attach the required additional certification to your application.

Page 4 Instruction

This page is used to enroll individual/group professional or institutional categories (from the listing) that are part of the business and subject to the Iowa Medicaid Provider Agreement. Additional copies of page 4 must be completed for each individual within the organization who is being enrolled. _Note: Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.

16. Enter the type code for the practice from the list on page 3
17. Enter the Licensee or “doing-business-as” name. For individuals that are part of an organization, list eh individual’s name
18. Enter the Tax ID of the entity to which payment will be made
19. Enter the requested effective date of the enrollment
20. Enter the physical address of the service location. Note that each service location must be listed for which medical records are stored, or for where MediPASS patients are seen. Make additional copies of page 4 as needed to indicate more than three service locations.
 - a. Enter the primary service address.
 1. Enter the phone number, fax number and e-mail address of the service location for which the application is being made
 - b. Enter an additional service location, if any
 1. Enter the phone number, fax number and e-mail address of the additional service location
 - c. Enter a third additional service address, if any
 1. Enter the phone number, fax number and e-mail address of the additional service location
21. Enter the pay-to-address. Only needed if the NPI being enrolled will be the pay-to
Note: Electronic Funds Transfer (EFT) Authorization Form is required if you will be enrolled using a Federal Employer Identification Number (FEIN) of the business and the NPI in box 23a will be the pay-to NPI. This address is used for mailing the debit card and 1099’s.
22. Enter mailing address
23. Enter National Provider Identifier (NPI)
 - a. Enter the NPI of the individual or organization named in box 17
 - b. Enter the taxonomy code of the billing provider. Note: if the individual listed in box 17 is a member of a group this box is not required and may be left blank

24. Primary Professional License or Certification Number

- a. Enter the primary professional license or certification number and attach a copy of your license or certification documents, as listed on page 3 for they type code listed in box 16
 - b. Enter the 10-digit Clinical Laboratory Improvement Amendments (CLIA) Certification code. If you are providing lab services, which require CLIA certification, submit a copy of your current CLIA certification
 - c. Enter the state in which this license/certification was issued
 - d. Enter the initial effective date of the license listed in box 24a
 - e. Enter the license expiration date for the license listed box 24a
 - f. Enter the effective date for the CLIA certificate listed in 24b
 - g. Enter the expiration date for the CLIA certificate listed in 24b
25. Enter the Drug Enforcement Agency (DEA) number. If the provider does not have a DEA number, enter N/A. If the provider is a physician, this must be entered
26. For physicians only: enter the primary specialty, if applicable
27. For physicians only: enter the secondary specialty, if applicable
28. Check the **Yes** box and attach an explanation if there has ever been disciplinary action against this provider's license by a licensing board in any state. Check **No** if there has not been any disciplinary action
29. Check the **Yes** box if Medicare or any State Health program has ever sanctioned the provider and attach an explanation. Check **No** is there have not been sanctions
30. Group Linkage Information- If the individual referenced in box 17 will be linked to a group, enter the group information here. Note: If the NPI, taxonomy and zip code provided do not match a group already enrolled in Iowa Medicaid the application will be returned for corrections. Page 4 must be completed to enroll a group.
- a. Enter the organization NPI with which the individual profession is associated. This is the NPI under which payments will be made
 - b. Enter the organizational taxonomy code
 - c. Enter the organizational zip code

Enter the name and signature of the person completing the form

Attachment A: Ownership & Control Disclosure

All providers (except individual CDAC) please complete section A and C (indicate “yes” or “no” in section C). If the provider is an organization other than an individual or a group you must also complete Section B.

Enter the full name, date of birth, social security number and NPI number for an individual. If the provider is an organization, provide the organization’s name, NPI and leave Date of Birth and Place of Birth fields blank.

Section

A: Disclosing Entities must disclose the following (attach additional pages if necessary):

- (1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more:
- (2) Whether any of the persons named, in compliance with paragraph (1) is related to another as spouse, parent, child or sibling.
- (3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.
- (4) The ownership of any subcontractor with whom the provider has had business transaction totaling more than \$25,000 during the 12-month period ending on the date of the request
- (5) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Section

B: Providers must disclose the identity of any person who:

- (1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider named above and,
- (2) Has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid or the title XX services program since the inception of these programs

Enter the names in this section if applicable. If there are no individuals who meet both these criteria, enter N/A.

Section

C: If the organization is a subsidiary company or joint venture, check No and skip this section. If yes, complete the remaining fields.

All providers completing this form must sign and date the form.