Iowa Department of Human Services

Iowa Medicaid HCBS Waiver Provider Application

Basic Information

To avoid delays in the enrollment process, you should:

- Complete all required forms listed below.
- If extra space is needed to answer any questions, please attach any additional pages.
- Type or print all information so that it is legible. Do not use a pencil.
- If any field is not applicable, please enter N/A.
- An incomplete form will delay the approval process.
- Attach all required supporting documentation.
- Make sure you read the instructions before completing the application.

Mail completed application and all applicable attachments to:

Iowa Medicaid Enterprise
Provider Services
P.O. Box 36450
Des Moines, IA 50315

For questions contact:

Provider Services, Enrollment:
Tel. (800) 338-7909 option 2 or
(515) 256-4609 option 2 (local)

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) must complete and submit the following forms:

- Form 470-2917 - Medicaid HCBS Waiver Provider Application (Sections: I and II)
- Form 470-2965 - Provider Agreement
- Form 470-4202 - EFT
- IRS Form W9
- Form 470-4612 - Individual CDAC Disclosure
- Form 470-4457 - Atypical Provider Declaration
- Form 470-4227 - Record Check Consent
- Proof of age (copy of driver's license, birth certificate, state issued ID, passport)

Agencies and businesses applying for waiver services must complete the following forms:

If you are enrolling in the Medicaid program for the first time or already enrolled, but you have a new Tax Identification Number, the following forms are required:

- Form 470-2917 - Medicaid HCBS Waiver Provider Application (Sections: I and III)
- Form 470-2965 - Provider Agreement
- Form 470-4202 - EFT
- IRS From W-9
- Form 470-5112 - Designated Contract Person

Agencies adding on waiver services:

If you are already enrolled and active, to add services to your existing enrollment the following form is required:

- Form 470-2917 - Medicaid HCBS Waiver Provider Application (Sections: I and III)

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

Reason for Application: Check one box.

Managed Care Organization (MCO): Check the box next to each MCO plan that you want your enrollment application submitted to.

I. General Section

1 **National Provider Identifier (NPI)** – Complete this section **only** if you are a current Iowa Medicaid Provider. Enter the NPI for the provider. If you do not have an NPI, enter your ten-digit Iowa Medicaid Provider number (beginning with "X00….).

2-7 Enter the location information for the provider.

8-9 **County Name and Number** – Enter the name and number of the county of residence (if out of state – enter the name and number of the county served).

10 **Telephone Number** – Enter area code and phone number.

11 **Cellular Telephone Number** – Enter area code and phone number, if available.

12 **Fax** – Enter area code and fax number, if available.

13 **Email Address** – Enter email address, if available. By providing your email address, you agree that we may communicate with you by electronic mail.

14 **Desired Effective Date for Enrollment** – This date cannot be retroactive before the first of the month in which the application is approved. Providers cannot bill or be paid for service provided prior to the Department of Human Services (DHS) approval of the service enrollment.

15 **County of Service** – Circle all counties that services will be provided.

II. Individual applicants applying for Consumer-Directed Attendant Care (CDAC)

If you are applying on behalf of an agency, proceed to section III.

If you are an **individual** applying for services other than Consumer-Directed Attendant Care, proceed to Section III. (**This is not common.**)

16 **Social Security Number** – Enter your social security number here.

17 **Check each box that applies:**

- ❑ – CDAC waiver types include: Health and Disability (H&D), AIDS/HIV (AH), Elderly (E), Intellectual Disability (ID), and Physical Disability (PD).
  - Individuals approved to provide CDAC waiver services will be enrolled in: ID, AH, E, ID, and PD.
  - Individuals who apply to provide CDAC waiver services are required to submit proof of age and must send in a copy of either a birth certificate **or** a driver's license. The date of birth must be clearly legible or it will not be accepted.
- ❑ – Brain Injury Waiver
  - Additional documentation is required for those wishing to provide Brain Injury Waiver services.

Note: The CDAC provider cannot bill or be paid for service provided prior to DHS written approval of this service. That is indicated by the case manager or DHS service worker attaching the *HCBS Consumer-Directed Attendant Care Agreement*, form 470-3372, to the service plan in the AIDS/HIV, Brain Injury, Elderly, Health and Disability, Intellectual Disability, and Physical Disability waivers. No payments will be made prior to the case manager's or DHS service worker's written approval of this service.

18-19 **Signature** – Original signature required. **Date** – Enter the date application is signed.

III. Agencies and businesses applying for waiver services

Managed Care Organization (MCO): Check the box next to each MCO plan that you want your enrollment application submitted to.

16 **Tax ID Number** – Enter your Internal Revenue Service (IRS) Tax ID number.

17 **Taxonomy code** – Enter the taxonomy code.

18-20 **Self-explanatory**.

21 Check Yes or No if you are enrolled in another state's Medicaid or CHIP program. If yes, please list the states and the program.

22 Check Yes or No if you are enrolled in Medicare.

23 Type of Ownership - check one.

24 Indicate which services you are applying for by checking the box next to that service. Under the service you are applying for check **one** of the standards that qualify you or your agency to provide that service. Next to the standard, circle the waiver type for which you are applying. Include with the application the documentation supporting the specific requirement that qualifies you or your agency to provide the service.

25 **Signature** – Original signature required. Applications not properly signed will be returned.

26 **Date** – Enter date application is signed. Applications not dated will be returned.

27 **Contact Person** – Enter the name of the person who should be contacted for questions regarding the application.

Note: Those wishing to provide services under the Brain Injury Waiver need to submit documentation indicating training or experience working with persons with an identified brain injury. The following services are exempt from the Brain Injury Waiver training requirement: Home or Vehicle Modification (HVM), Specialized Medical Equipment (SME), Personal Emergency Response (PERS), and Transportation.

Form 470-4547 is required when enrolling for services that require submission of a complete Provider Quality Management Self-Assessment and/or submission of policies, procedures and forms.

Once the application process has been approved, you will receive notification from the Iowa Medicaid Enterprise (IME).

Iowa Medicaid HCBS Waiver Provider Application

Individual applicants applying to provide Consumer-Directed Attendant Care (CDAC) should complete sections I and II. Agencies and businesses applying to provide waiver services should complete sections I and III.

I. GENERAL SECTION

Reason for Application: Check one box.

☐ You are a **NEW** enrollee in Iowa Medicaid (the Tax Identification or Social Security Number has not been enrolled in Medicaid)	☐ You are **REACTIVATING** your Iowa Medicaid provider number	☐ You are **CHANGING** to a new Tax Identification Number (if you are already enrolled, but have a new Tax Identification Number)	☐ You are **ADDING-ON** additional services to an existing enrolled Iowa Medicaid provider

Please indicate which MCO(s) the IME should share your application with:

☐ Amerigroup Iowa ☐ UnitedHealth Care Plan of the River Valley	

By checking the box above I authorize the Iowa Medicaid Program to share this application and all information contained herein with each MCO indicated above.

1. **National Provider Identifier (NPI) (if you are not currently a Medicaid provider, leave blank)**	
2. **Provider Name**	
3. **Mailing Address**	
4. **Street Address (if different from the mailing address)**	
5. **City**	6. **State**
7. **Zip Code (please enter 9-digit zip code, if known)**	–
8. **County Name**	9. **County Number**
10. **Telephone Number (daytime)**	( ) –
11. **Cellular Telephone Number (optional)**	( ) –
12. **Fax Number (if available)**	( ) –
13. **Email Address (please, print)**	
14. **Desired Effective Date for Enrollment (MM/DD/YYYY)** (THIS DATE WILL NOT BE RETROACTIVE BEFORE THE FIRST OF THE MONTH IN WHICH THE APPLICATION IS APPROVED)	/ /

15. **Circle all counties you will be providing services in:**

1 Adair	11 Buena Vista	21 Clay	31 Dubuque	41 Hancock	51 Jefferson	61 Madison	71 O'Brien	81 Sac	91 Warren
2 Adams	12 Butler	22 Clayton	32 Emmet	42 Hardin	52 Johnston	62 Mahaska	72 Osceola	82 Scott	92 Washington
3 Allamakee	13 Calhoun	23 Clinton	33 Fayette	43 Harrison	53 Jones	63 Marion	73 Page	83 Shelby	93 Wayne
4 Appanoose	14 Carroll	24 Crawford	34 Floyd	44 Henry	54 Keokuk	64 Marshall	74 Palo Alto	84 Sioux	94 Webster
5 Audubon	15 Cass	25 Dallas	35 Franklin	45 Howard	55 Kossuth	65 Mills	75 Plymouth	85 Story	95 Winnebago
6 Benton	16 Cedar	26 Davis	36 Fremont	46 Humboldt	56 Lee	66 Mitchell	76 Pocahontas	86 Tama	96 Winneshiek
7 Black Hawk	17 Cerro Gordo	27 Decatur	37 Greene	47 Ida	57 Linn	67 Monona	77 Polk	87 Taylor	97 Woodbury
8 Boone	18 Cherokee	28 Delaware	38 Grundy	48 Iowa	58 Louisa	68 Monroe	78 Pottawattamie	88 Union	98 Worth
9 Bremer	19 Chickasaw	29 Des Moines	39 Guthrie	49 Jackson	59 Lucas	69 Montgomery	79 Poweshiek	89 Van Buren	99 Wright
10 Buchanan	20 Clarke	30 Dickinson	40 Hamilton	50 Jasper	60 Lyon	70 Muscatine	80 Ringgold	90 Wapello	

If you are an individual applying for Consumer-Directed Attendant Care (CDAC), please proceed to section II, otherwise proceed to section III.

II. Application for Individual Consumer-Directed Attendant Care

16. Social Security Number				–			–				

Service and Requirements

17. Check the box(es) below for each HCBS Waiver program for which application is being made:

☐ – **Consumer-Directed Attendant Care (CDAC)** waiver types include: H&D, AH, E, ID, and PD.

- Individual Applicant (Attach a photocopy of birth certificate **or** driver's license. The document must show name and date of birth.)

☐ – **Brain Injury Waiver** waiver type is: BI

Those wishing to provide CDAC services under the Brain Injury Waiver must submit documentation indicating training or experience working with persons with an identified brain injury.

To demonstrate that you meet the criteria to be enrolled as a Brain Injury Waiver provider, please submit one or more of the following:

- Training certificates;
- Credentials (Brain injury specialist, RN, LPN, OT, PT, CNA license);
- Resumé including a detailed description of job duties and employment start and end dates;
- A signed and dated personal statement from the applicant detailing experience with working hands on direct care with persons with a brain injury diagnosis;
- A signed and dated personal statement that you reside in the household of the member, and/or are the parent of the member who will be receiving the CDAC services and demonstrate that you have provided instruction on the care of the individual member or a brain injury professional;
- A signed and dated personal statement that you been providing direct care to a person with a brain injury. List the types of assistance and support you have provided and the length of time that you have been providing those services;
- Online training available at: https://secureapp.dhs.state.ia.us/lowatbi/ . This course, or equivalent, is required for HCBS/BI waiver service provision.

Upon receipt of the documentation, it will be reviewed for approval. If the documentation is found to be insufficient, you will be required to take an approved training for individuals with a brain injury. You cannot become a Brain Injury Waiver provider without attending training or having the training waived through your experience and outside training.

Read and sign the following statement:

As a Medicaid provider of consumer-directed attendant care services:

- I understand that if I am the parent or stepparent of a consumer aged 17 or under, or the spouse of a consumer, that I may not provide services to those individuals.
- I understand that I may not provide consumer-directed attendant care services for a consumer for whom I am a caretaker and for whom I am the beneficiary of respite services that are funded by an HCBS waiver.
- I understand that all consumer-directed attendant care service activities are supportive. I must be qualified by prior training and/or experience and/or a certificate of formal training to carry out the consumer's plan of care pursuant to the department approved service plan.
- I understand that I must describe in detail my training and/or experience on form 470-3372, *HCBS Consumer-Directed Attendant Care Agreement*, and this will be reviewed and approved by the Medicaid case manager or service worker for appropriateness of training and/or experience prior to provision of services. Form 470-3372 becomes an attachment to and a part of the service plan. I will receive direction and training from consumers for activities to maintain independence that are not medical in nature. I will receive from licensed nurses and therapists on-the-job training and supervision for skilled activities described on form 470-3372. All training and experience must be sufficient to protect the health, welfare, and safety of the consumer.
- I have made a copy of this application for my own records.

STATEMENT
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION IN, OR RELATED TO, THIS APPLICATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL (INCLUDING A FALSE CLAIMS LAWSUIT) AND/OR ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION
I HEREBY CERTIFY that I have read the above statement, and that I have examined this application and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am familiar with the laws and regulations governing the medical assistance program (Iowa Medicaid) and that I am duly qualified to participate as a provider in that program. I PROMISE to apprise Iowa Medicaid immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by Iowa Medicaid related to or arising out of this application.

18. Signature

19. Date			/			/				

Iowa Department of Human Services

Individual Consumer-Directed Attendant (CDAC) Disclosure

All Individual CDAC Providers Must Complete

1. Provider Name	2. Date of Birth
3. Social Security Number (SSN)	
4. List all states in which you lived over the age of 18 for more than a period of one month	
5. List all names and aliases that you have used in your life	

6. Pursuant to 42 CFR § 455.106 (2011), certain Medicaid providers must make ownership and controlling interest disclosures. Individual providers are not required to make these disclosures. Are you applying to Medicaid to deliver service as an individual CDAC provider?

- ☐ Yes, I am an individual provider. Continue below.
- ☐ No, I am not an individual provider. You are required to make the disclosures mentioned above and must complete form 470-0254.

Pursuant to 42 CFR § 455.106, you must disclose whether you, an agent, or managing employee has a "final adverse action" related to your or that person's involvement in any program under Medicare, Medicaid, or Title XX. "Final adverse actions" include convictions, exclusions, revocation or suspensions. See the complete definition on page 3.

Check one:

- ☐ No, I (or any agent or managing employee) have not received final adverse action related to any program under Medicare, Medicaid, or the Title XX services program.
- ☐ Yes, I (or any agent or managing employee) have received final adverse action related to any program under Medicare, Medicaid, or the Title XX services program. Who is the adverse action against?
  - ☐ Self
  - ☐ Agent or managing employee:_____

Attach a separate sheet with a detailed explanation of the final adverse action. Include with your explanation, the nature of the adverse action, date(s), name of person charged with the adverse action, names of others involved, and final adverse action.

7. Have you ever been charged with any criminal offenses, including traffic offenses? ☐ YES ☐ NO If **YES**, attach a separate sheet with each offense listed. List the original charge; the result of the charge, including but not limited to, a formal conviction, deferred judgment, probation, acquittal, or exoneration; all the relevant location and dates.
8. Have you ever been named as responsible party in a founded child abuse case? ☐ YES ☐ NO If **YES**, attach a separate sheet with each accusation of abuse listed. List the original charge; the result of the charge, including but not limited to, whether the charge was founded or unfounded, resulted in a formal conviction, deferred judgment, probation, acquittal, or exoneration; all the relevant location and dates.
9. Have you ever been named as responsible party in a founded dependent adult abuse case? ☐ YES ☐ NO If **YES**, attach a separate sheet with each accusation of abuse listed. List the original charge; the result of the charge, including but not limited to, whether the charge was founded or unfounded, resulted in a formal conviction, deferred judgment, probation, acquittal, or exoneration; all the relevant location and dates.

STATEMENT:

Misrepresentation or falsification of any information in or related to this document may be punishable by criminal, civil (including a false claims lawsuit) and/or administrative action, fine and/or imprisonment under federal and/or state law.

CERTIFICATION:

I **hereby certify** that I have read the above statement and that I have examined this document and all accompanying documents, and that to the best of my knowledge and belief, each is true, correct, and complete. I further certify that I am familiar with the laws and regulations governing the medical assistance program (Iowa Medicaid) and that I am duly qualified to participate as a provider in that program. I PROMISE to apprise Iowa Medicaid immediately of any material changes to this application and provide true, correct, and complete answers to any subsequent questions of me by Iowa Medicaid related to or arising out of this application.

Provider Signature	Date

Final adverse actions include the following:

Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, revocations, or suspensions include:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Iowa Department of Human Services

Iowa Medicaid Provider Agreement General Terms

This Agreement is between the State of Iowa, Department of Human Services (the "Department"), and the Provider or Group Provider and its members or Practitioner(s) (the "Provider"). The operations management responsibility for the Iowa Medicaid Program is through the Iowa Medicaid Enterprise (the "IME").

Section 1. Provider Agrees to:

1.1 Adhere to professional standards and levels of service as set forth in all applicable local, State and Federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by the Department relating to the Provider's performance under this Agreement.

1.2 Abide, to the extent required, by the provisions of:

1.2.1 Title VI of the Civil Rights Act of 1964 as amended (42 U.S.C. § 2000e), which prohibits discrimination against any employee or applicant for employment or an applicant or member of services, on the basis of race, religion, color, national origin, age or sex.

1.2.2 Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794) as well as the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and associated regulations found at 28 C.F.R. §§ 36.101 through 36.999, which prohibit discrimination against disabled persons.

1.2.3 The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations found at 45 C.F.R. parts 160 and 164, and all laws protecting the confidentiality of patient information.

1.3 Comply with applicable Federal, State and local laws, regulations, administrative rules, and executive orders when performing services under the Agreement, including without limitation, all laws applicable to the prevention of discrimination in employment, and business permits and licenses that may be required to perform services under the Agreement.

1.4 Comply with all applicable Federal and State laws, administrative rules and written policies of the Iowa Medicaid program, including but not limited to Title XIX of the Social Security Act (as amended), the Code of Federal Regulations, the Federal anti-kickback statute and the Stark law, the provisions of the Code of Iowa and administrative rules of the Iowa Department of Human Services and written Department policies, including but not limited to, policies contained in the Iowa Medicaid Provider Manual, and the terms of this Agreement. This section neither creates nor negates due process rights of either party.

1.5 Comply with the applicable advance directive requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMOs specified in 42 C.F.R. §§ 489.100 through 489.104 and 42 C.F.R. § 417.436. For hospital, facility and home health agency providers, the Provider shall provide all members with written information regarding their rights to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives (durable power-of-attorney for health care decisions and declarations).

1.6 Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. Provider agrees to check the HHS-OIG website (http://exclusions.oig.hhs.gov/ or https://oig.hhs.gov/exclusions/index.asp) by the name of any individual or entity for their exclusion status before the Provider hires or enters into any contractual relationship with the person or entity. In addition, Provider agrees to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Provider must report to the IME any exclusion information discovered through such searches.

The Department is generally prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under the Medicaid program that are furnished by an excluded individual or entity, and extends to (1) all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system, (2) payment for administrative or management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid members, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and (3) payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program. In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded. *See* 42 C.F.R. § 1001.1901(b).

1.7 In accordance with 42 C.F.R. § 455.104, Provider shall report ownership and control information as follows:

1.7.1 *What disclosures must be provided.* Provider shall report the following:

1.7.1.1 The name and address of any person (individual or corporation) with an ownership or control interest in the Provider. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

1.7.1.2 The date of birth and Social Security Number (in the case of an individual).

1.7.1.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in the Provider or in any subcontractor in which the Provider has a 5 percent or more interest.

1.7.1.4 Whether the person (individual or corporation) with an ownership or control interest in the Provider is related to another person with ownership or control interest in the Provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

1.7.1.5 The name of any other disclosing entity (or fiscal agent or managed care entity) in which the owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

1.7.1.6 The name, address, date of birth, the Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

1.7.2 *When the disclosures must be provided.* Disclosures from Provider are due:

1.7.2.1 Upon Provider submitting the proposal in accordance with the State's procurement process.

1.7.2.2 Upon Provider executing a Provider Agreement with the State.

1.7.2.3 Upon renewal or extension of the Provider Agreement.

1.7.2.4 Within 35 days after any change in ownership of Provider.

1.7.3 *To Whom Must the Disclosures Be Provided.* All disclosures must be provided to the Department.

1.7.4 *Consequences for Failure to Provide Required Disclosures.* Federal financial participation (FFP) is not available in payments made to a provider that fails to disclose ownership or control information as required by law.

1.8 Provider will furnish to the Department or to the Secretary of HHS on request, information related to business transactions in accordance with 42 C.F.R. § 455.105. Specifically, Provider will:

1.8.1 Submit, within 35 days of the date on a request by the Secretary or the Department, full and complete information about:

1.8.1.1 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; and

1.8.1.2 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.

1.8.2 FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph 1.8 of this section or under 42 C.F.R. §420.205.

1.9 In accordance with 42 C.F.R. § 455.106, Provider shall disclose information on persons convicted of crimes as follows:

1.9.1 *Information that must be disclosed.* Upon signing this Agreement and prior to renewal of the Agreement, or at any time upon written request by the Department, Provider must disclose to the Department the identity of any person who:

1.9.1.1 Has ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and

1.9.1.2 Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX program since the inception of those programs.

1.9.2 Notification to Inspector General.

1.9.2.1 The Department must notify the Inspector General of the HHS of any disclosures made under subsection 1.9.1 of this Agreement within 20 working days from the date it receives the information.

1.9.2.2 The Department will also promptly notify the Inspector General of HHS of any action it takes on the Provider's application for participation in the program.

1.9.3 *Denial or Termination of Provider Agreement/Provider Status.*

1.9.3.1 The Department may refuse to enter into or renew an Agreement with a Provider if the Provider or any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX program.

1.9.3.2 The Department may refuse to enter into or may terminate the Agreement if it determines that the Provider did not fully and accurately make any disclosure required under subsection 1.9.1 of this Agreement.

1.10 Comply, to the extent required, with 42 U.S.C. § 1396a(a)(68), and the requirements of the False Claims Act by:

1.10.1 Establishing written policies for all employees that include detailed information about the False Claims Act and the other provisions set forth in 42 U.S.C. § 1396a(a)(68). The policies must include detailed information about the Provider's policies and procedures for detecting and preventing waste, fraud, and abuse.

1.10.2 Including in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion of the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

1.11 Comply with those Federal requirements and assurances for recipients of Federal grants provided in OMB Standard Form 424B (4-88) applicable to the Provider. The Provider is responsible for determining which requirements and assurances are applicable to the Provider. The Provider shall provide for the compliance of any subcontractors with applicable Federal requirements and assurances.

1.12 Be aware of and acknowledge that payment of claims will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State law.

1.13 Comply with 42 U.S.C. § 1395cc(j) by disclosing any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program, has been excluded from participation under Medicare, Medicaid or title XXI programs or has had its billing privileges denied or revoked.

1.14 Meet, on a continuing basis, the State and Federal licensure, certification or other regulatory requirements for Provider's specialty, including all provisions of the State of Iowa Medical Assistance law, or any rule or regulation promulgated pursuant thereto.

1.15 Refrain from conduct prohibited by 31 U.S.C. § 1352 and 45 C.F.R. § 93.100 et seq., which restrict the payments of federally appropriated funds to any person for influencing or attempting to influence an officer or employee of any agency, a member of the U.S. Congress, an officer or employee of the U.S. Congress, or an employee of a member of the U.S. Congress in connection with the awarding of any Federal contract, the making of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

1.16 For Provider Groups: To warrant that the group has authority to bind all member providers to this Provider Agreement; to provide the Department with names of practitioners in the group with proof of current licensure for each practitioner; to provide name(s) of individual(s) with authority to sign billings on behalf of the group; and to provide each member Provider with a copy of this Agreement.

Section 2. Reimbursement

2.1 The Provider acknowledges that this Agreement is based on the Provider's performance of the services contemplated hereunder. Department agrees to pay for medically necessary goods and/or services actually and properly provided to the Department-enrolled Medicaid member. All such goods and/or services must have been rendered by Provider in accordance with Federal and State law and the State policies and procedures set forth in the Iowa Medicaid Provider Manual. Financial obligations of the State of Iowa are contingent upon funds for that purpose being appropriated.

2.2 The Provider agrees to pursue the member's other health coverage prior to submitting a claim for goods and/or services to the IME. This includes but is not limited to Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any other third party insurance.

2.3 The Provider receiving payment shall accept payment from the Department (and any applicable co-pay) as payment in full on behalf of the member, and agrees not to bill, retain or accept payments for any additional amounts except as provided for in paragraph 2.2 above;

2.4 The Provider shall immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department. In the event that the Provider owes the State any sum under the terms of this Agreement, any other Agreement, pursuant to any other debt subject to the law of set off, the State may set off the sum owed to the State against any sum owed by the State to the Provider in the State's sole discretion, unless

otherwise required by law. The Provider agrees that this provision constitutes proper and timely notice under the law of set off.

2.5 The Provider shall report and return any overpayment by the later of a) 60 days after the date on which the overpayment is identified or b) the date any corresponding cost report is due, if applicable.

2.6 The Department may make any necessary adjustment to payments to the Provider in order to satisfy any past-due obligations of a provider that has the same taxpayer identification number, regardless of whether the Provider is assigned a different billing number or national provider identification number.

2.7 The Department may withhold payments, in whole or in part, upon receipt of reliable evidence of fraud or willful misrepresentation as specified in 42 C.F.R. § 455.23. Department shall fully document the reliable evidence it evaluated in making a decision to withhold payment. If the Department has evidence of fraud or willful misrepresentation on the part of the Provider, the Department may notify the Provider of the temporary suspension of this Agreement. If Provider has been notified of the temporary suspension of this Agreement, Provider may not bill for services rendered to eligible members during the period of the suspension.

Section 3. Notices

With the exception of amendments made pursuant to § 5.10 of this Agreement, all written notices or communication shall be deemed to have been given when delivered in person; or, if sent to address on file by first-class United States mail, proper postage prepaid. Provider shall notify the Department and/or IME within thirty-five (35) days of any change that must be reported pursuant to a notice or disclosure requirement contained in this Agreement, including but not limited to (1) suspension, revocation or limitations placed on the Provider's license or certifications, (2) indictment, arrest or conviction for a criminal offense related to the provision of goods and/or services under a federally-funded health care program, (3) change in ownership or control, and (4) change in address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds.

Section 4. Records

4.1 The Provider shall maintain books, records and documents which sufficiently and properly document and calculate all charges billed to the Department throughout the term of this Agreement for a period of at least five (5) years following the date of final payment or completion of any required audit. Records to be maintained include both financial records and service records. The Provider shall permit the Auditor of the State of Iowa or any authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records or other records of the Provider relating to orders, invoices or payments or any other documentation or materials pertaining to this Agreement, wherever such records may be located. The Provider shall not impose a charge for audit or examination of the Provider's books and records.

4.2 Provider shall maintain adequate medical, financial, and administrative records as stated in the Iowa Medicaid Provider Manual relating to all goods and/or services rendered by Provider under this Agreement. In order to perform its utilization management, quality improvement activities, audits and fraud control unit activities, the Department and/or the IME, Federal employees, and/or authorized representatives shall be given access to the business or facility and all related member information and records, including claims records, and information regarding payments claimed by the Provider for furnishing services under this Agreement. The Provider shall provide copies of such records free of charge and in a timeframe consistent with 441 Iowa Admin. Code § 79.3 or as otherwise agreed to by Provider and the Iowa Medicaid Program.

Section 5. Miscellaneous

5.1 Incorporation of Documents. Both parties mutually agree that the Department Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein. The Provider agrees to notify the Iowa Medicaid Enterprise Provider Services Unit, P.O. Box 36450, Des Moines, IA 50315 within 30 days of a change in any of the information in the Provider Enrollment Application.

5.2 Independent Contractor. Provider is an independent contractor providing goods and/or services paid for by the Department. Neither the Provider nor any of the Provider's employees, agents and any subcontractors performing under this Agreement are employees or agents of the State of Iowa or any agency, division or department of the State. Neither the Provider nor its employees shall be considered employees of the Department or the State of Iowa for federal or state tax purposes. The Department will not withhold taxes on behalf of the Provider (unless required by law). The Provider is solely responsible for and shall meet all legal requirements, including payment of all applicable taxes, workers compensation, unemployment and other premiums, deductions, withholdings, overtime and other amounts, which may be legally required with respect to the Provider, and the employment of all persons providing goods and/or services under this Agreement.

5.3 Certification Regarding Sales and Use Tax. By executing this Agreement, the Provider certifies it is either (a) registered with the Iowa Department of Revenue, collects, and remits Iowa sales and use taxes as required by Iowa Code chapter 423; or (b) not a "retailer" or a "retailer maintaining a place of business in the state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Provider also acknowledges that the Department may declare the Agreement void if the above certification is false. The Provider also understands that fraudulent certification may result in the Department or its representative filing for damages for breach of contract.

5.4 Assignment/Change of Control. This Agreement may not be assigned, transferred or conveyed in whole or in part without the prior written consent of the Department. For the purpose of construing this clause, a transfer of a controlling interest in the Provider shall be considered an assignment.

5.5 Choice of Law and Forum. The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Agreement without regard to the choice of law provisions of Iowa law. In the event of any proceeding of a quasi-judicial or judicial nature is commenced in connection with this Agreement, the proceeding shall be brought and maintained in Polk County District Court for the State of Iowa, Des Moines, Iowa or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Department or the State of Iowa.

5.6 Drug Free Workplace. The Provider shall provide a drug free workplace in accordance with the Drug Free Workplace Act of 1988 and all applicable regulations.

5.7 Not a Joint Venture. Nothing in this Agreement shall be construed as creating or constituting the relationship of a partnership, joint venture, (or other association of any kind or agent and principal relationship) between the parties hereto. Each party shall be deemed to be an independent contractor contracting for services and acting toward the mutual benefits expected to be derived from the Agreement. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or binding upon another party to this Agreement.

5.8 Severability. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, such determination shall not affect the validity or enforceability of any other part or provision of this Agreement.

5.9 Third Party Beneficiaries. There are no third-party beneficiaries to this Agreement. This Agreement is intended only to benefit the State, the Department, and the Provider.

5.10 Amendment. The Department may amend this Agreement from time to time by posting an updated version on the Provider Services website at: http://www.ime.state.ia.us/Providers/index.html and providing notice of the amended Agreement to the Provider by issuing a bulletin/informational letter. The Provider shall be deemed to have accepted the amendment, unless the Provider notifies the Department of its non-acceptance of the new provisions of the Agreement within 30 days of the notice. Such notice of non-acceptance of the amendment shall constitute notice of termination of this Agreement effective upon receipt of such notice.

5.11 Supersedes Former Agreements. Once the Department enrolls the Provider, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of health care goods and/or services to members of the Iowa Medicaid Program.

5.12 This Agreement shall remain in full force and effect to the end of the specified term or until terminated or canceled pursuant to administrative rules published by the Department. All obligations of the Department and the Provider incurred or existing under this Agreement as of the date of expiration, termination or cancellation will survive the termination, expiration or conclusion of this Agreement.

5.13 The parties to this Agreement hereby expressly indicate their mutual intent to incorporate into this Agreement all applicable laws, rules, regulations, guidance, and policies as those laws, rules, regulations, guidance, and policies existed at the time of Agreement execution as well as all future amendments, changes, and additions to all applicable laws, rules, regulations, guidance, and policies. The parties to this Agreement expressly reject any proposition that future changes in applicable law, rule, regulation, guidance, and policy are inapplicable to this Agreement and the parties' performance pursuant to the Agreement.

5.14 The Provider shall immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department. In the event that the Provider owes the State any sum under the terms of this Agreement, any other Agreement, pursuant to any other debt subject to the law of set off, the State may set off the sum owed to the State against any sum owed by the State to the Provider in the State's sole discretion, unless otherwise required by law. Furthermore, the Provider recognizes the right of the Department to have the Department's contracted managed care organizations set off payments to be made to the Provider to satisfy such debts owed to the State. The Provider agrees that this provision constitutes proper and timely notice under the law of set off. Providers may appeal any such set offs pursuant to the Department's rules at 441 Iowa Admin. Code chapter 7.

Section 6. Termination

6.1 The Provider may terminate this Agreement at any time. Payments will be made for goods and/or services rendered up to and including the date of termination. The Provider will promptly supply all information necessary for the reimbursement of any outstanding claims.

6.2 The Department may terminate this Agreement, upon thirty (30) days written advance notice to the Provider of goods and/or services after it has determined:

6.2.1 The Provider of goods and/or services is not substantially complying with the provision of the Agreement as set forth herein; or,

6.2.2 The Provider of goods and/or services has not submitted any claims for goods and/or services rendered to members of the Iowa Medicaid program for a period of twenty-four (24) months. In such cases, the Department will notify the Provider of goods and/or services that unless the Provider notifies the Department within a period of thirty (30) calendar days from receipt of such notice, the Department will assume the Provider of goods and/or services wishes to voluntarily terminate its participation in the Iowa Medicaid

Program. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

6.3 The Department may terminate this Agreement in accordance with 441 Iowa Admin. Code chapter 79.

6.4 The Department may terminate this Agreement immediately after it has determined the Provider's State license or certification under Title XVIII of the Social Security Act (Medicare) has been terminated or suspended by a competent authority.

6.5 Absent early termination of this Agreement pursuant to the provisions of this Section, this Agreement shall remain in full force and effect for a term of five (5) years from the effective date established during the enrollment process.

Section 7. Business Associate Agreement

All Providers who are MediPASS patient managers, Wellness patient managers, Health Home Providers, and/or Accountable Care Organizations are Business Associates of the Department. ("Business Associate Provider"). The Business Associate Provider performs certain services on behalf of the Department pursuant to this Provider Agreement that require the exchange of information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended, and the federal regulations published at 45 CFR part 160 and 164. The Business Associate Provider agrees to comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted to the Department's website: http://dhs.iowa.gov/hipaa. This BAA, and any amendments thereof, is incorporated into the Provider Agreement by reference.

Section 8. Qualified Service Organization

Providers who are also Business Associates acknowledge that they may be receiving, storing, processing, or otherwise dealing with confidential patient records from programs covered by 42 CFR part 2. Such Business Associate Providers acknowledge that they are fully bound by those regulations as a "Qualified Service Organization." The term "Qualified Service Organization" as used in this Agreement has the same meaning as the definition set forth in 42 CFR § 2.11. Business Associate Providers will resist in judicial proceedings any efforts to obtain access to patient records covered by 42 C.F.R. part 2 except as permitted by these regulations.

Provider:	
Provider Business Entity Name:	
Federal Tax ID or Social Security #:	
Authorized Official's Name:	**Title:**
Authorized Official Signature:	**Date:**

Form **W-9**
(Rev. October 2004)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.

Name (as reported on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

Social security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

or

Employer identification number
___ ___ – ___ ___ ___ ___ ___ ___ ___

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- an individual who is a citizen or resident of the United States,
- a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- any estate (other than a foreign estate) or trust. See Regulation section 301.7701-6(a) for additional information.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

Iowa Department of Human Services

Request and Acknowledgement to Conduct Registry and Record Check

I understand and acknowledge that the Iowa Department of Human Services (hereinafter "Department") is required by statute to conduct Child Abuse Registry, Dependent Adult Abuse Registry, Sexual Offender Registry checks and/or DCI/FBI Criminal History Record checks for specific categories of persons who have direct contact with the Department's clients, provide Department approved services for the Department's clients or have access to IRS Federal Tax Information and hereby request the Department conduct such a Registry and/or Record check regarding me.

Nothing within this form shall be construed as a guarantee to have direct contact with the Department's clients or provide Department approved services for the Department's clients.

Sexual Offender Registry

I hereby request and give permission to the Department to conduct a Sexual Offender Registry check. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the Department's clients or provide Department approved services for the Department's clients.

Signature	Date

Child Abuse Registry

I hereby request and give permission to the Department to conduct a Child Abuse Registry check. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the Department's clients or provide Department approved services for the Department's clients.

Signature	Date

Dependent Adult Abuse Registry

I hereby request and give permission to the Department to conduct a Dependent Adult Abuse Registry check. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the Department's clients or provide Department approved services for the Department's clients.

Signature	Date

Criminal History Record

I hereby request and give permission to the Department to conduct a DCI and FBI Criminal History Record check. I further give permission to the Department to conduct such a registry check at any time while I have direct contact with the Department's clients, provide Department approved services for the Department's clients or have access to IRS Federal Tax Information.

Signature	Date

Information Required for Registry and Record Check

(Please type or print legibly.)

Last Name	First Name	Middle Name	Maiden Name (if applicable)
Alias (if applicable)	Alias (if applicable)	Alias (if applicable)	Alias (if applicable)
Date of Birth	Gender	Social Security Number	Reason for Check Select Reason From List
Address			City
State	ZIP	☐ This is an initial check. ☐ This is a renewal or recheck.	

For DHS Employees, Volunteers or Contractors ***only***	
Position	
Central Office	Service Area
CSRU/TCM	Institution

For Child Care Center Employees or Volunteers ***only***
Requestor Name
Mailing Address

IRS Federal Tax Information Background Check		
Last Name	First Name	Date

If a position requires access to IRS Federal Tax Information, we are required to run background checks for all locations where you have lived, worked or gone to school during the last **five** years.

☐ **IRS Federal Tax Information Background Check Required**
If this box is checked, the position you are applying for or are currently in requires this check.

Please list the addresses where you have lived, worked or gone to school during the last **five** years below:

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Address		
City	State	ZIP
Dates you lived, worked or attended school in this location:		

Please attach additional sheets if necessary.

Iowa Department of Human Services

Atypical Provider Declaration

The undersigned is in the process of submitting an application to the Iowa Department of Human Services to be a provider of services to Iowa Medicaid members. By signing this Declaration Form, we/I declare and attest that the provider category or categories for which the application is being made does not meet the definition of health care provider as defined in 45 C.F.R. § 160.103 and is/are not eligible to receive a National Provider Identifier (NPI). Instead, the applicant will be an "atypical" provider in each of the categories listed below. Provider categories are listed on the Iowa Medicaid Provider Application, 470-0254. **Note: Individuals providing Consumer Directed Attendant Care fall under the "waiver" Provider Category.**

Provider name:	Tax Identification/Social Security Number:

Provider Category (list all that apply):

Provider Category
Example: Waiver

If additional space is needed, please print this form or write on the back of this form.

Name of person completing this form:
Signature:

Please return completed form to: **Iowa Medicaid Enterprise**
Attn: Provider Enrollment
P.O. Box 36450
Des Moines, IA 50315
Email: IMEProviderServices@dhs.state.ia.us

Iowa Department of Human Services

Electronic Fund Transfer (EFT) Authorization

This form must be completed by providers to receive claim payments via Electronic Funds Transfer (EFT). This form must be completed upon initial enrollment, if you change your financial institution, or if there is a change in your financial account status.

- Electronic version of this EFT Authorization Form
- Electronic Funds Transfer (EFT) Authorization Form (470-4202) Instructions

Provider Information

Provider Name		
Street		
City	State/Province	Zip Code/Postal Code

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
National Provider Identifier (NPI)

Provider Contact Information *(Contact information of the person completing this form)*

Provider Contact Name	
Telephone Number	Telephone Number Extension
Email Address	

Financial Institution Information

Financial Institution Name		
Street		
City	**State/Province**	**Zip Code/Postal Code**
Financial Institution Routing Number	**Type of Account at Financial Institution** ☐ **Checking** ☐ **Savings**	
Provider's Account Number with the Financial Institution		
Account Number Linkages to Provider Identifier ☐ **Provider Tax Identification Number (TIN)** ☐ **National Provider Identifier (NPI)**		

Reason for Submission*

☐ New Enrollment ☐ Enrollment Change ☐ Cancel Enrollment

* *This enrollment submission must include a "voided check" or a bank letter that contains the name and address of the financial institution with the matching account information contained on this form.*

Authorized Signature and Date (Check the statement below.)

☐ By signing this document I authorize (check the box) the Iowa Medicaid Program to apply my Medicaid payments to the account specified above. I understand that payment is made from state and federal funds and that any falsification or concealment of a material fact may be prosecuted under state and federal laws. I understand that my electronic signature certifies acceptance of the provider certification on the claim form and/or Provider Agreement. I also certify that I am legally authorized to make this certification, and that I may be prosecuted under applicable state or federal laws for any false statements or documents submitted.

You may fill out, print, and mail or fax the completed form to:

Iowa Medicaid Enterprise
Attn: Provider Enrollment
PO Box 36450
Des Moines, IA 50315
Fax to (515) 725-1155
Email: IMEProviderEnrollment@dhs.state.ia.us