



Claim for Targeted Medical Care

If handwritten, use blue or black ink only. **Accuracy** is important.
This form may be downloaded at www.amerhealthcaritasia.com.

Member information

1. AmeriHealth Caritas Iowa ID number	2. Member's name
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Provider information

3. NPI provider number	4. Provider's name		
5. Provider address			
6. ZIP code	7. Medicaid ID number	8. Taxonomy code	9. Tax ID number

Other information

10. Other health insurance Name of other insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Other health insurance denied	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Other health insurance payment		13. Client participation amount	

Services

14. Procedure code	15. Modifier	16. Place of service	17. First date	18. Last date	19. Units	20. Total line charges
21. Total claim charges: \$						

Corrected claim

If this is a corrected claim, please complete this section. If the original claim number is not provided, the corrected claim will be rejected.

22. Corrected claim
Original claim number: _____

Important reminder on corrected claims: In addition to this section, please provide all of the information on the original claim, changing only the fields that need to be corrected. This claim will replace all of the claim information submitted on the original claim.

Authorized signature(s)

By signing, I agree that I am submitting this claim in compliance with the terms and conditions on the back of this form.	For consumer-directed attendant care claims only.
Provider signature	Member or guardian signature
Date	Date



Terms and conditions

I hereby agree:

- To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.
- To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.
- To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment and spend down.
- To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
- To adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and remain in compliance with AmeriHealth Caritas Iowa's FWA program, as applicable.

I certify that:

- The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.
- The charges for these services are just, unpaid, actually due according to the law and program policy, and not in excess of regular fees.
- The information provided on the front of this claim is true, accurate and complete.

I understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.

Place of service codes

11 Office	51 Inpatient psychiatric facility
12 Home	53 Community mental health center
21 Inpatient hospital	54 Intermediate care facility/MR
22 Outpatient hospital	55 Residential substance abuse treatment facility
23 ER room hospital	56 Residential psychiatric treatment facility
24 Ambulatory surgical center	61 Comp inpatient rehab facility
31 Skilled nursing facility	62 Comp outpatient rehab facility
32 Nursing facility	71 Public health clinic
33 Custodial care facility	99 Place of service
34 Hospice	

Complete claim form instructions and a printable version of this form are available on our website: www.amerihealthcaritasia.com. For additional questions on how to complete the form, please call Provider Services at **1-844-411-0579**.

Mail the completed claim form to:
 AmeriHealth Caritas Iowa
 P.O. Box 7113
 London, KY 40742