



Iowa Department of Human Services

Accident Injury Request

<<NAME>>
<<ADDRESS>>
<<ADDRESS>>
<<CITY>>, <<STATE>> <<ZIPCODE>>

<<Date>>

Reference Number: <<<<<>>>>>

Important Notice: If this form is not completed in writing or over the phone, Medicaid benefits *may* be canceled.

<<First Name Last Name>> received treatment for an accident or injury. The information on the back of this form must be completed to see if somebody else should have paid for the treatment.

A parent or legal guardian should complete and sign the form for a child under the age of 18, or call Iowa Medicaid Member Services at 1-800-338-8366 to complete the information over the phone. Iowa Medicaid Member Services will need the reference number. Please return the form using one of the following ways by <<DueDate>>.

Email: RevCoLLLIen@dhs.state.ia.us

Fax: 515-725-1352

Mail: Iowa Medicaid Enterprise
Revenue Collections
P.O. Box 36446
Des Moines, IA 50315

Phone: Member Services
1-800-338-8366
or locally in the Des Moines area at **515-256-4606**
Monday through Friday, 8:00 am to 5:00 pm

Para solicitar este documento en español, comuníquese con Servicios a los Miembros al teléfono 1-800-388-8366, de lunes a viernes desde las 8:00 a.m. hasta las 5:00 p.m.

**Complete Accident Injury Request form and return it by <<DueDate>>:
If this form is not completed in writing or over the phone,
Medicaid benefits *may* be canceled.**

<<First Name Last Name>>, <<Medicaid ID>>

Date of Treatment: <<date of service>>
Provider's Name: <<Provider's name>>

Reference Number: <<<<<>>>>

Was the treatment a result of an accident or injury? Yes No
If no, sign and date this form. See the front page on how to return the form.

If yes, did the accident or injury happen on <<Date of service>>? Yes No
If no, please tell us the correct date of the accident or injury. ____/____/____
(mm/dd/yyyy)

Tell us what happened and what the injuries were. If more space is needed, attach a separate sheet of paper.

Has a lawyer been hired? Yes No If yes, complete this section.

Name of Lawyer		Phone Number	
Address			
City		State	ZIP Code

Was a claim filed with an insurance company? Yes No If yes, complete this section.

Insurance Company Name		Contact Name	
Address			
City		State	ZIP Code
Phone Number		Claim Number	
Policy Holder Name		Policy Number	

Sign, date, and return the completed form using the instructions on the front side.

Signature		Date	
Print name		Relationship to member	
Home Phone Number		Cell Phone Number	