



Iowa Medicaid Managed Health Care Enrollment Form

You may use this form to enroll with the MediPASS or an HMO. If you have any questions about how to complete this form or your enrollment options, call 1-800-338-8366 or 515-256-4606, Monday-Friday from 8:00 am – 5:00pm. To complete this form, follow the instructions listed below:

1. List the name and Person ID number for each person you wish to enroll. The Person ID number is listed on the Notice of Decision you received in this packet.
2. If choosing MediPASS, please review the list of MediPASS doctors provided with this packet. Choose a Doctor/Clinic for each name and fill in the form below with the name and address in the middle section of the table below. Also tell us the county your Doctor/Clinic is in using the far right section of the table below.
3. If you live in a county that has an HMO and you would like to select the HMO, please write the name of the HMO in the **Doctor/Clinic/HMO Name** column, next to each member's name.
4. After you complete the form, sign your name on the bottom line.
5. Fold the form so that the BUSINESS REPLY MAIL shows on the outside. Wet along the side of the form to seal. You do not need a stamp to mail this form.

The County you live in: _____

Today's date: _____

Print the name of each person to enroll	Date of Birth	Person ID number	Doctor/Clinic/HMO Name	Address	County the Doctor or Clinic is in

Reason for changing provider: _____

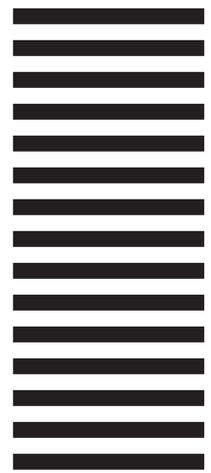
Your address (Street, City and Zip Code)

Your Phone

Sign Here



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 781 DES MOINES IA

POSTAGE WILL BE PAID BY ADDRESSEE

**IOWA DEPARTMENT OF HUMAN SERVICES
IOWA MEDICAID MEMBER SERVICES CALL CENTER
PO BOX 36510
DES MOINES IA 50315-9936**

