Iowa Department of Human Services
Iowa Medicaid Program

PROVIDER INQUIRY

Please check the type of inquiry below:

☐ Inquiry about payment or medical determination of a **specific claim** (TCN below)

☐ **General Issue** regarding Medicaid policy (an example TCN may be reference below)

Attach supporting documentation. Check applicable boxes:

☐ Claim form ☐ Remittance copy ☐ Other pertinent information for possible claim reprocessing

INQUIRY

1. **17-DIGIT TCN** * Required if about a specific claim

2. NATURE OF INQUIRY:

Date	MAIL TO: IME Provider Services P. O. BOX 36450 DES MOINES IA 50315	Date
Provider Signature:		IME Signature:

Provider Please Complete:

Provider NPI#

Member ID#

Phone Number

Name

Address

City State Zip Code

(FOR IME USE ONLY)

PR Inquiry Log #

Received Date Stamp: