

Iowa Department of Human Services

**Request for Patient Eligibility**

Iowa Medicaid Pharmaceutical Case Management Program

CONFIDENTIALITY WARNING: The information contained in this facsimile message is privileged and confidential information intended only for the review and use of the Iowa Medicaid program or the provider listed below. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication or the information contained herein is strictly prohibited. If you have received this communication in error, please immediately notify sender or call 515-725-1008 or 1-800-383-1173, and destroy original documents.

**Important Note:**

**Some insurance (TPL) and Medicare Part D plans already cover this type of service. For Medicaid members who have TPL or Medicare Part D the provider must show that the TPL/Medicare D does not cover this service when submitting a claim to IME. Call provider services if you have any questions about how to submit a claim in such cases: 1-800-338-7909 or 515-725-1004 (local in Des Moines).**

**In addition, the provider is responsible for verifying any other coverage and ongoing Medicaid eligibility – Medicaid is always “payer of last resort.” If the member becomes eligible for Medicare (or other insurance) while receiving Pharmaceutical Case Management (PCM), primary coverage of the service may change. Approval for PCM service does not guarantee that coverage of the service is with Medicaid.**

Member Name \_\_\_\_\_ Medicaid ID Number \_\_\_\_\_

This member has the following disease states: (check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Ischemic Heart Disease   | <input type="checkbox"/> Atrial Fibrillation  |
| <input type="checkbox"/> Diabetes Mellitus        | <input type="checkbox"/> Osteoarthritis       |
| <input type="checkbox"/> Hypertension             | <input type="checkbox"/> GERD                 |
| <input type="checkbox"/> Hyperlipidemia           | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> COPD                 |

Does this member take four or more regularly scheduled medications? Yes No  
*(Do not include topical medications or PRN medications.)*

If yes, please list four of this member’s scheduled medications.

\_\_\_\_\_  
\_\_\_\_\_

Does this patient reside in a nursing facility? Yes No

I submitted this information to be true to the best of my knowledge.

\_\_\_\_\_  
Provider Signature 470-4361 (Rev. 7/09) Provider Name

\_\_\_\_\_  
Pharmacist's NPI Number Required

\_\_\_\_\_  
Provider Fax Number *(need for response)*

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Pharmacy Telephone Number

**Please fax this completed form to 515-725-1355.**

**This portion will be completed by the Eligibility Processing Unit and faxed to you. However, this document does not guarantee patient eligibility for Medicaid.**  
According to the information you have provided, this member  IS  IS NOT  
eligible for Iowa Medicaid Pharmaceutical Case Management services.