Iowa Department of Human Services

Iowa Medicaid

Ordering/Referring Provider Enrollment Application

Providers who order or refer items/services to Medicaid members are required to be enrolled in the Medicaid program.

1. Type Code	**2.** Licensee Name		**3.** National Provider Identifier (NPI)	
4. Professional License Number	**5.** Social Security Number		**6.** Date of Birth	
7. Primary Service Address	City		State	Zip Code
Primary Address Phone Number	Fax Number		Email	
8. Mailing Address	City		State	Zip Code
9. Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.				
10. Has there ever been disciplinary action against this provider's license by a licensing board in any state? ☐ **Yes** ☐ **No** **IF "YES" PLEASE ATTACH AN EXPLANATION**				
11. Has the provider ever been sanctioned by Medicare or any state health program? ☐ **Yes** ☐ **No** **IF "YES" PLEASE ATTACH AN EXPLANATION**				
12. Has the provider been convicted of a criminal offense related to involvement in any program under, Medicare, Medicaid, or the Title XX services program? ☐ **Yes** ☐ **No** **IF "YES" PLEASE ATTACH AN EXPLANATION**				
13. Are you employed or contracted with one of the following provider types: Rural Health Care Clinic, Federally Qualified Health Center, or Community Mental Health Center? ☐ **Yes** ☐ **No** **If "YES" complete below**				
National Provider Identifier (NPI)	Taxpayer Identification Number (TIN)			
Name of Person Completing This Form		**Signature of Person Completing This Form**		
Email Address of Person Completing This Form		**Phone Number of Person Completing This Form**		
Practitioner Signature		**Date**		

THE PROVIDER CERTIFIES THAT THE INFORMATION SUBMITTED ON THIS ENROLLMENT FORM IS, TO THE BEST OF THE PROVIDER'S KNOWLEDGE, TRUE, ACCURATE AND COMPLETE AND THAT THE PROVIDER HAS READ THIS ENTIRE FORM BEFORE SIGNING. THE PROVIDER ALSO UNDERSTANDS PENALTIES FOR FALSIFYING INFORMATION MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINSTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL AND /OR STATE LAW. BY SIGNING THE ENROLLMENT APPLICATION, YOU AGREE TO ADHERE TO MEDICAID'S LAWS AND REGULATIONS & PROGRAM INSTRUCTIONS. BY SIGNING THE ENROLLMENT APPLICATION YOU ALSO ACKNOWLEDGE THAT YOU MAY BE DENIED ENTRY TO OR REVOKED FROM THE MEDICAID PROGRAM IF ANY REQUIREMENTS ARE NOT MET.

Instructions for Completing the Iowa Department of Human Services Iowa Medicaid Order/Referring Provider Enrollment Application

- Please type or print information
- If any field is not applicable, please enter N/A
- If extra space is needed to answer any questions, please attach any additional page(s)
- An incomplete form may delay the approval of this application

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1. Refer to attached listing of Iowa Medicaid provider types. Use this list to identify your provider type code.
2. Enter the licensee name.
3. Enter the individual National Provider Identifier (NPI) number in box 3.
4. Enter the professional license or certification number and attach a copy of your license or certification documents.
5. Enter the 9-digit Social Security Number for the individual entered in box 2.
6. Enter the date of birth for the individual entered in box 2.
7. Enter the primary service location, phone number, fax number.
8. Enter mailing address only if different than address in box 7.
9. Enter the Drug Enforcement Agency (DEA) number. If the provider does not have a DEA number, enter N/A.
10. Check the **Yes** box and attach an explanation if there has ever been disciplinary action against this provider's license by a licensing board in any state. Check **No** if there has not been any disciplinary action.
11. Check the **Yes** box if Medicare or any State Health program has ever sanctioned the provider and attach an explanation. Check **No** if there have not been sanctions.
12. Check the **Yes** box if convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid or the Title XX services program and attach an explanation. Check **No** if there have been no convictions.
13. Check the **Yes** box if employed or contracted with one of the provider types listed. Enter the NPI number of the Rural Health Clinic, Federally Qualified Health Center or Community Mental Health Center and enter their Taxpayer Identification Number. Check **No** if no further entries are needed.

Enter the name of the person completing this form, signature, email address and phone number. Practitioner must sign and date form.

Provider Type List
(Enter type code in box 1)

Practitioners who are eligible to enroll in Medicaid under Iowa Administrative Code 441 subchapter 77. These provider types include, but are not limited to the following:

Type Code	Category
2	PHYSICIAN MD
3	PHYSICIAN DO
4	DENTIST
5	PODIATRIST
6	OPTOMETRIST
7	OPTICIAN
15	PHYSICAL THERAPIST
16	CHIROPRACTOR
17	AUDIOLOGIST
29	PSYCHOLOGIST
38	CERTIFIED NURSE MIDWIFE
44	CRNA
48	CLINICAL SOCIAL WORKER
50	NURSE PRACTITIONER
68	PHYSICIAN ASSISTANTS

With the implementation of Section 6401 of the Affordable Care Act all ordering and referring providers are required to enroll. Medicaid permits practitioners to enroll in the Medicaid program for the purpose of meeting this requirement without impacting the payment arrangement the provider may have with facilities or supervising providers. These practitioners do not and will not send claims to the Medicaid program for the services they furnish.

Medicaid does **not** require form (470-4202) “Electronic Funds Transfer Authorization” Form.

For questions relating to this application please contact the Iowa Medicaid Enterprise Provider Services Unit at 1-800-338-7909 or locally at 515-256-4609,Option 2.

Return the completed enrollment form to:

Provider Services Unit
Iowa Medicaid Enterprise
P.O. Box 36450
Des Moines, IA 50315