IOWA HHS

Iowa Department of Health and Human Services

Iowa Medicaid Integrated Health Home Provider Application

Provider Type: ☐ 73 Integrated Health Home		Requested Effective Enrollment Date	
Primary Service Address	City	State	Zip (9-digit)
Primary Service Address Phone Number	Fax		
Additional Service Address	City	State	Zip (9-digit)
Additional Service Address Phone Number	Fax		
Additional Service Address	City	State	Zip (9-digit)
Additional Service Address Phone Number	Fax		
Additional Service Address	City	State	Zip (9-digit)
Additional Service Address Phone Number	Fax		
Organizational NPI (National Provider Number)	Taxonomy Code		

Has there ever been disciplinary action against any provider's licenses by a licensing board in any state?

☐ Yes ☐ No If yes, please attach an explanation

Has any provider ever been sanctioned by Medicare or any state health program?

☐ Yes ☐ No If yes, please attach an explanation

Are you currently enrolled in another state's Medicaid or CHIP program?

☐ Yes ☐ No If yes, please attach an explanation

Are you currently enrolled in Medicare?

☐ Yes ☐ No

Agency Accreditation/Licensure (e.g., CMHC,PMIC, CARF, etc)

Effective date of accreditation/licensure	Term date of accreditation/licensure

Is your current accreditation/licensure included with application (e.g., CARF, CMHC, PMIC, etc.)?
(Must be included to process application)

☐ Yes ☐ No

Please attest that each health home requirement listed below has been met.	
▪ Able to provide community-based mental health services to the target population.	☐ Yes
▪ Has a Patient Registry.	☐ Yes
▪ Has a certified Electronic Health Record (EHR).	☐ Yes
▪ Is participating in the Iowa Health Information Network.	☐ Yes
▪ Has expanded hours for access.	☐ Yes

The provider certifies that the information submitted on this enrollment 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 that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Provider Business Entity Name (type or print name)
Federal Tax ID #:
Authorized Official's Contact Phone and Email Address
Authorized Official's Name (type or print name)
Title
Authorized Official's Signature
Date

Please Mail to:

Iowa Medicaid Provider Services
P.O. Box 36450
Des Moines, IA 50315
Or email to: IMEProviderEnrollment@dhs.state.ia.us