



Iowa Department of Human Services
ICD-10 External Testing Registration Form

In preparation for ICD-10 implementation, Iowa Medicaid encourages all providers to begin testing ICD-10 claim submissions as soon as possible. Two testing options are available through Iowa Medicaid for Level 3 External Testing: End-to-End (E2E) and Business-to-Business (B2B). This form is to be used by Providers/Clinics/Organizations who wish to register for ICD-10 Testing.

Provider/Clinic/Organization Name		
Address		
City	State	Zip
Telephone	Fax Number	
Contact Name	Contact Email	
Tax ID Number	Billing NPI Number	

Schedule of ICD-10 Testing: (Please check to indicate your choice(s))

Business to Business (B2B) Testing		
	B2B Testing Cycle 2	February 17 – March 2, 2015
	B2B Testing Cycle 3	March 11 – March 24, 2015
	B2B Testing Cycle 4	April 2 – April 15, 2015
	B2B Testing Cycle 5	April 24 – May 7, 2015
	B2B Testing Cycle 6	May 18 – May 29, 2015
	B2B Testing Cycle 7	June 9 – June 22, 2015
	B2B Testing Cycle 8	July 1 – July 14, 2015
	B2B Testing Cycle 9	July 23 – August 5, 2015
End to End (E2E) Testing		
	E2E Testing Cycle 2	February 17 – March 2, 2015
	E2E Testing Cycle 3	March 11 – March 24, 2015
	E2E Testing Cycle 4	April 2 – April 15, 2015
	E2E Testing Cycle 5	April 24 – May 7, 2015
	E2E Testing Cycle 6	May 18 – May 29, 2015

E2E Testing Cycle 7	June 9 – June 22, 2015
E2E Testing Cycle 8	July 1 – July 14, 2015
E2E Testing Cycle 9	July 23 – August 5, 2015

Please include any Rendering and/or Treating NPI numbers that will be submitted on ICD-10 test claims.

Certification Statement:

Please check each statement below to express your agreement. Each statement below must be checked for access to be granted.

I authorize the Iowa Medicaid Enterprise (IME) to verify the information submitted on this form.

I certify that I am the individual practitioner or representative and that I have the right to access patient information contained on this secure site.

I understand that if I terminate any agreement with the IME or my employer, then it is my responsibility to terminate my access to this site effective immediately.

After filling out this registration form, you can submit the completed form as an email attachment by clicking on the “SUBMIT” button below.

This registration form may also be submitted:

By Fax: 5157251155

By Mail: Provider Correspondence
PO Box 36450
Des Moines, IA 50315

For any inquiries, please contact Provider Services at ICD-10project@dhs.state.ia.us