

## Section B: Organizational Data – Master Provider Listing

Use this list to identify your provider type code. Enter the type code in box 16.

- Declare all individual professionals and institutional categories (from the listing below) that are part of this business and subject to the Iowa Medicaid Provider Agreement.
- Attach current certification document(s) as indicated on the list below.
- Only the individuals or institutional categories listed by the business on this form are eligible for Medicaid reimbursement.
- **Categories in bold below are considered Moderate or High risk and subject to a pre/post enrollment site visit and other enhanced screening requirements.**

Type Code	Category	Primary Certification	Additional Certification
1	General Hospital	CMS certification	License *CLIA
2	Physician MD	License	*CLIA
3	Physician DO	License	*CLIA
4	Dentist	License	
5	Podiatrist	License	
6	Optometrist	License	
7	Optician		
8	Pharmacy	License	Medicare enrollment
9	<b>Home Health Agency</b>	CMS certification	
10	<b>Independent Lab</b>	CLIA certificate	Medicare enrollment
11	<b>Ambulance</b>	License	
12	<b>Medical Supplies</b>	Medicare enrollment	
13	Rural Health Clinic	CMS certification	
14	ESRD	CMS certification	
15	<b>Physical Therapist</b>	License	Medicare enrollment
16	Chiropractor	License	Medicare enrollment
17	Audiologist	License	
18	Skilled Nursing Facility	DIA/CMS certification	License
19	<b>Rehab Agency</b>	CMS certification	
20	Intermediate Care Facility	DIA/CMS certification	License
21	<b>Community Mental Health</b>	Bureau of Community Services	
22	Family Planning	Dept Public Hlth approval	
23	Residential Care Facility	License (DIA)	
25	ICF/ID State	DIA/CMS certification	License
26	Mental Hospital	CMS certification	License
27	Community-Based ICF/ID	DIA/CMS certification	License
29	Psychologist	License	NRHSPP cert
30	Screening Center	Dept Public Health approval	
31	Hearing Aid Dealer	License	
32	Occupational Therapists	License	Medicare enrollment
34	Orthopedic Shoe Dealer		
35	Maternal Health Center	DHS approval	
36	Ambulatory Surgical Center	CMS certification	
38	Certified Nurse Midwife	License	Board cert *CLIA
39	Birthing Center	DHS approval	
40	Area Education Agency	IA Dept of Education Agreement	
41	Psych Medical Inst. Children (PMIC)	DIA license	
42	Case Manager	DHS approval	
44	CRNA	License	Board cert
45	<b>Hospice</b>	CMS certification	*CLIA
48	Clinical Social Worker	License	Medicare enrollment
49	Federal Qualified Health Center (FQHC)	CMS certification	HRSA grant
50	Nurse Practitioner	License	Board cert *CLIA
52	Nursing Facility - Mentally Ill	DIA/CMS certification	License
54	County Relief	DHS approval	
55	Lead Investigation Agency	Dept Public Hlth approval	
56	Local Education Agency	IA Dept of Education Agreement	
57	Early Access Service Coordinator	IA Dept of Education Agreement	
58	PACE	CMS PACE agreement	
62	Behavioral Health	License	
63	Behavioral Hlth Intervention Srvs (BHIS)	Magellan enrollment welcome letter	
64	Habilitative Services	Applicable certification/accreditation	
67	Assertive Community Treatment (ACT)	License	
69	Independent Speech Pathologist	License	
71	Health Home	TransforMED self-assessment or NCQA recognition	Health home agreement
72	Public Health Agency	Board of Health Jurisdiction letter	
99	Waiver	HCBS application required	

**Please copy this information and complete one for each individual professional and institutional category that is part of this business and subject to the Iowa Medicaid provider agreement.**

<b>16.</b> Type Code		<b>17.</b> Licensee or DBA Name		<b>18a.</b> Tax ID (for billing entity)	
<b>18b.</b> Social Security Number		<b>18c.</b> Date of Birth		<b>19.</b> Requested Effective Date of Enrollment*	
<b>20a.</b> Primary Service Address		City		State	Zip
<b>20a1.</b> Primary Address Phone Number		Fax		Email	
<b>20b.</b> Additional Service Address		City		State	Zip
<b>20b1.</b> Additional Service Address Phone Number		Fax		Email	
<b>20c.</b> Additional Service Address*		City		State	Zip
<b>20c1.</b> Additional Service Address Phone Number		Fax		Email	
<b>21.</b> Pay-to Address		City		State	Zip
<b>22.</b> Mailing Address		City		State	Zip
<b>23a.</b> National Provider Identifier (NPI)			<b>23b.</b> Taxonomy Code (if applicable)		
<b>24a.</b> Primary Professional License or Certification Number – <b>Please attach a copy of your license/certification documents.</b>			<b>24b.</b> 10-Digit CLIA Number		<b>24c.</b> State Issued
<b>24d.</b> Initial Effective Date	<b>24e.</b> Current Expiration Date		<b>24f.</b> CLIA Effective Date	<b>24g.</b> CLIA Expiration Date	
<b>25.</b> Drug Enforcement Agency (DEA) Number. If the provider does not have a DEA Number, enter N/A.					
<b>26.</b> Primary Specialty* (if applicable)			<b>27.</b> Secondary Specialty* (if applicable)		
<b>28.</b> Has there ever been disciplinary action against this provider's license by a licensing board in any state? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <b>If "Yes," please attach an explanation.</b>					

**29a.** Has the provider ever been sanctioned by Medicare or any state health program?

Yes  No If "Yes," please attach an explanation.

**29b.** 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.

**Payment Method Information: EFT is required when billing under a Federal Tax ID Number. Debit Card is only an option if an individual is doing business under a Social Security Number.**

**Group Linkage Information\***

Individual professionals may be associated with an organization. If that is the case, identify the organization in the boxes below:

**30a.** Organizational NPI

**30b.** Organizational Taxonomy

**30c.** Organization Location Zip

**31.** Are you currently enrolled in another state's Medicaid/CHIP program?

Yes  No If "Yes," please list the state and what program you are enrolled in:

**32.** Are you currently enrolled with Medicare?  Yes  No

**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.**

**33a.** Printed Name of Legal Entity

**33b.** Printed Name and Title of Authorized Signatory

**33c.** Signature of Authorized Signatory

**33d.** Signature Date

**Please mail this completed Provider Application and all applicable attachments to:  
Iowa Medicaid Enterprise, Attn: Provider Enrollment,  
PO Box 36450, Des Moines, Iowa 50315**