Claim for Targeted Medical Care

If handwritten, use blue or black ink only. **Accuracy** is important.

This form may be downloaded at **www.amerihealthcaritasia.com**.

Member information

1. AmeriHealth Caritas Iowa ID number	2. Member's name

Provider information

3. NPI provider number		4. Provider's name	
5. Provider address			
6. ZIP code	7. Medicaid ID number	8. Taxonomy code	9. Tax ID number

Other information

10. Other health insurance ❑ Yes ❑ No Name of other insurance	11. Other health insurance denied ❑ Yes ❑ No
12. Other health insurance payment	13. Client participation amount

Services

14. Procedure code	15. Modifier	16. Place of service	17. First date	18. Last date	19. Units	20. Total line charges
			21. Total claim charges: $			

Authorized signature(s)

By signing, I agree that I am submitting this claim in compliance with the terms and conditions on the back of this form.	For consumer-directed attendant care claims only.
Provider signature	Member or guardian signature
Date	Date

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Terms and conditions

I hereby agree:

- To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.
- To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.
- To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment and spend down.
- To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
- To adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and remain in compliance with AmeriHealth Caritas Iowa's FWA program, as applicable.

I certify that:

- The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.
- The charges for these services are just, unpaid, actually due according to the law and program policy, and not in excess of regular fees.
- The information provided on the front of this claim is true, accurate and complete.

I understand that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.

Place of service codes

11	Office
12	Home
21	Inpatient hospital
22	Outpatient hospital
23	ER room hospital
24	Ambulatory surgical center
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
51	Inpatient psychiatric facility
53	Community mental health center
54	Intermediate care facility/MR
55	Residential substance abuse treatment facility
56	Residential psychiatric treatment facility
61	Comp inpatient rehab facility
62	Comp outpatient rehab facility
71	Public health clinic
99	Place of service

Complete claim form instructions and a printable version of this form are available on our website: **www.amerihealthcaritasia.com**.
For additional questions on how to complete the form, please call Provider Services at **1-844-411-0579**.

Mail the completed claim form to:
AmeriHealth Caritas Iowa
P.O. Box 7113
London, KY 40742