Iowa Medicaid Enterprise
Iowa Department of Human Services
Claim For Targeted Medical Care 470-2486(Revised 8/14)
Form Instructions

The table below follows the revised Claim for Targeted Medical Care by field number, field name/description, whether or not that field is required, and a brief description of the information that needs to be entered in that field, and how it needs to be entered.

Accuracy is important, please type. If handwritten please print legibly, and use only blue or black ink.

Use the original claim form or the downloadable version available on the DHS website at: http://dhs.iowa.gov/ime/Providers/claims-and-billing/ClaimsPage. If you have any questions about this form or to order blank forms, contact Provider Services at 1-800-338-7909 or locally (in the Des Moines area) at 515-256-4609.

Field No.	Field Name/Description	Requirements	Instructions
MEMBER INFORMATION			
1	Medicaid ID Number	REQUIRED	Enter the member's Medicaid ID number found on the Iowa Medicaid Eligibility Card. The ID number consists of seven digits followed by a letter (Example: 1234567A) Note: Please do not include any dashes or punctuation within the ID number.
2	Member's Name	REQUIRED	Enter the member's last name, first name, and middle initial.
PROVIDER INFORMATION			
3	NPI Provider Number	REQUIRED	Enter the NPI of the provider. Note: Please do not include any dashes or punctuation prior to or within the NPI Provider Number.
4	Provider's Name	REQUIRED	Enter the name of the provider.
5	Provider Address	REQUIRED	Enter the address of the provider.
6	Zip Code	REQUIRED	Enter the zip code associated with the provider's address.

7	Taxonomy Code	Situational	Required if the NPI reported in box 3 does not begin with an “X.” In this case, enter the taxonomy code associated with the provider. If NPI starts with “X00,” leave this field blank.
8	Other Health Insurance	REQUIRED	Indicate whether or not the member has other insurance that covers the services billed, by checking "yes"
9	Other Health Insurance Denied	Situational	Required if the member has other insurance that has denied payment. Check "yes" if the member's other insurance has denied payment. Check "no" if the other insurance
10	Other Health Insurance Payment	Situational	Required if a payment was made by other insurance (other than Iowa Medicaid) for the services billed. Enter the total amount of payments paid by other insurance (if If more than one claim form is used to bill for services and a prior payment was made by insurance other than Iowa Medicaid, the prior payment should be entered on each page of Note: The total must include both dollars and cents (Example: $150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.

11	Client Participation Amount	Situational	Enter the amount that the member is contributing. If none, leave blank. If more than one claim form is used to bill for services and the member owes Client participation (CP), the CP should be entered on each page of the claim in Box 11. Note: The total must include both dollars and cents (Example: $150.00). Failure to include both dollars and cents may result in a payment different from what you
SERVICES			
12	Procedure Code	REQUIRED	Enter the five-digit service code for each service being billed on the claim. Note: Please do not include any dashes or punctuation within the procedure code.
13	Modifier	Situational	Leave blank, except when the Notice of Decision indicates that a procedure code modifier is necessary.
14	Place of Service	REQUIRED	Enter the two-digit place of service code of each service being billed on the claim.
15	First Date	REQUIRED	Enter the FIRST date that services were provided for the month being billed in MM/DD/YY format. Note: Please wait until the month following the month that services were provided to bill the claim. (Ex: Date of Service 1/1/12-1/31/12, do not complete claim or mail until 2/1/12.)

16	Last Date	REQUIRED	Enter the LAST date that services were provided for the month being billed in MM/DD/YY format. Note: A line can only contain services that took place in a single month. If service took place in multiple months, you must list the services provided in each month on separate lines. (Example: Line 1- DOS 1/1/12-1/31/12; Line 2- DOS 2/1/12-2/29/12.)
17	Units	REQUIRED	Enter the total number of units being billed for each line. Note: All units should be entered using whole numbers only (i.e. “1”). Do not indicate partial units or anything after a decimal (i.e. “1.5”).
18	Total Line Charge	REQUIRED	Enter the total charge for each line. Note: The total must include both dollars and cents (Example: $150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.

19	Total Claim Charges	REQUIRED	Enter the sum of the total line charges (column 18). If more than one claim form is used to bill services performed, only the last page of the claim should give the claim Total Charge. The pages prior to the last page should have “continued” or “page __ of __” in Box 19. Note: The total must include both dollars and cents (Example: $150.00). Failure to include both dollars and cents may result in a payment different from what you were expecting.
AUTHORIZED SIGNATURE(S)			
	Provider Signature/ Date	REQUIRED	The provider must sign and date the claim.
	Member/Guardian Signature/ Date	Situational	Required if any procedure billed is for Consumer Directed Attended Care (CDAC). The member or member’s guardian must sign and date the claim when CDAC services are billed. Note: If the member’s guardian is signing the claim, the guardian must sign their own name, and indicate that they are the guardian. A guardian should not sign the member’s name.