

PROVIDER INFORMATION SHEET
 Audiological Services and Hearing Aid Funding

FACILITY

Name: _____

Address: _____

Tax ID Number: _____

Contact Person _____ Title: _____

Telephone: (_____) _____ E-mail address: _____

BILLING INFORMATION –AS PRINTED ON THE CLAIM

Name _____

Address: _____

Contact Person _____ Title: _____

Telephone: (_____) _____ E-mail address: _____

INDIVIDUAL HEALTH CARE PROVIDERS

Enter professionals' employed/paid by facility that may provide services to children with Audiological funding.

| PROVIDER NAME | MEDICAID PROVIDER YES/NO | NPI NUMBER |
|---------------|--------------------------|------------|
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| | | |

 Signature of Facility Representative

 Date

By accepting payments based on Iowa Medicaid rates for services covered by this program, you are agreeing to consider this payment as payment in full with required provider liability and further agree to not bill the patient for remaining balances on covered services.

Submit to:
 PROVIDER CLAIM SYSTEMS
 PO BOX 1608
 MASON CITY, IOWA 50616
 800.547.6789
 (Fax) 641.422.2713