Iowa Department of Public Health
Promoting and Protecting the Health of Iowans

Mariannette Miller-Meeks, B.S.N., M.Ed., M.D.
Director

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

To: Health Care Providers
From: Iowa *Care for Yourself* Program
Re: Information about Provider Participation

Thank you for agreeing to serve as a health care provider in the *Care for Yourself* program. As a health care provider you are helping to provide education, screening and referrals for uninsured, underinsured and underserved women in the *Care for Yourself* program that include:

- Early detection and treatment of breast and cervical cancers and
- Cardiovascular disease risk factors such as: hypertension, hyperlipidemia, and overweight/obesity.

The program is supported by the Iowa Department of Public Health (IDPH) and funded through the Centers for Disease Control and Prevention.

If there are several clinical site offices in your practice with the same tax ID number, only one cooperative agreement with the Iowa Department of Public Health is needed. However, each clinic site will need to fill out an "Application for *Care for Care for Yourself* Provider Status" page to identify providers in each of the offices. Contracts are not in effect and providers are not reimbursed until the Iowa Department of Public Health signs the Cooperative Agreement.

Here is a quick list of how to become an Iowa *Care for Yourself* program health care provider:

- Complete and sign the Cooperative Agreement (only one signature per facility).
- Complete the Application for Provider Status, listing the names of all providers at your facility providing Iowa *Care for Yourself* services.
- Submit the signed application and cooperative agreement, **and** a copy of the facility W-9 form to

  Iowa *Care for Yourself*
  Lucas State Office Building, 4th Floor
  321 E. 12th Street
  Des Moines, IA 50319-0075

Please notify IDPH in writing of the following changes to prevent delayed reimbursement. If, after signing an agreement,

- Facility is assigned a new tax identification number or
- Name or address of the facility changes, or
- Provider changes in the clinic site.

Notification is to be done by submitting an "Update Application for Provider Status," form with the new information.

The *Care for Yourself* Program has local program sites with staff throughout the state that will assist navigating clients through the services. It is important for you to know and work with the local program coordinator/staff in your area as patient care procedures and referral processes need to be followed. Orientation and training about the *Care for Yourself* program can be provided for you and your staff. To request orientation and training, please contact local program or state staff at 800-369-2229.

Iowa Department of Public Health
Care for Yourself

Vital Information about Provider Participation

- **Participation** in this program is voluntary.
- **Become** familiar with and use the *Health Care Provider Guide* that will arrive with your copy of the *Cooperative Agreement*.
- **Basic services** for a woman enrolled in the *Care for Yourself (CFY)* program require the following types of health care providers: primary care, laboratory, pathologist, mammography, radiologist and surgeon. When a primary care provider wishes to participate in the program, the laboratory, mammography facility, surgeon and anesthesiologist/anesthetist needs to have a signed *Cooperative Agreement* whom the primary provider utilizes.
- A ***Cooperative Agreement*** must be established between each service provider (primary care provider, laboratory, mammography facility and associated specialty provider) and IDPH. Only one representative (with legal authority) per facility must sign. The Cooperative Agreement will be effective once the *CFY* agreement is signed by IDPH.
- ***Application for Provider Status*** form must be completed and submitted to the Iowa Department of Public Health (IDPH) for each provider location using your tax ID.
- **Reimbursement** to providers for services to *CFY* women cannot be made unless a signed Cooperative Agreement is on file at IDPH.
- **Reimbursement rates**, set by federal legislation, are determined according to current Medicare Part B rates.

CHANGE OF STATUS

Use the *Update of Application for Provider Status* form to notify the *Care for Yourself* program of any of the following:

- Change of professional staff.
- Change of laboratory or mammography facility being used.
- Change to a new or different facility. (Note: each facility must have a signed *Cooperative Agreement* for the individual provider to continue as a participant in the *CFY* program.)
- Change in professional status, licensing, certification, etc.
- Change of tax ID number.

CONTACT

Contact the Iowa *CFY* program at 1-800-369-2229
with any questions or for more information.

Mail to: Iowa *CFY* program, Iowa Department of Public Health, Lucas State Office Building 4th Floor, 321 E. 12th Street, Des Moines, IA 50319-0075

Local Program contact information may be found at
www.idph.state.ia.us/webmap/default.asp?map=careforyourself.

INSTRUCTIONS FOR APPLICATION TO PARTICIPATE IN THE
Care for Yourself Program

Please complete and return Cooperative Agreement, Application for Provider Status, copy of facility W-9 and CLIA certification, if applicable.

COOPERATIVE AGREEMENT

- Enter the facility name, mailing address and tax ID number on page 1.
- A person authorized to enter into a contract for the facility must sign and date the agreement on page 5.
- Facility W-9 - For reimbursement purposes, please include a copy of the Facility W-9 form.
- CLIA CERTIFICATION - If your facility will be providing and billing for the clinical laboratory portion of the *Care for Yourself* Program, please provide a copy of your lab's CLIA CERTIFICATION.

APPLICATION FOR PROVIDER STATUS

Definitions for items on the APPLICATION FOR PROVIDER STATUS need to be completed:

Facility Name: The name of the clinic or entity that will request and receive payment.

Facility Contact Person: The name of the person who can answer questions pertaining to your facility and individual providers.

Billing Name and Address: The name and address that will appear on the reimbursement claim.

Billing Contact Person: The name of the person who can answer questions pertaining to claims submitted for reimbursement.

Billing and Facility Contact Information: E-mail addresses, phone and fax numbers for the contact persons named above.

Service Type(s): Circle all the categories that apply. A hospital facility that provides laboratory services should circle laboratory and hospital. Do not circle services that are provided under contract or other arrangement and billed separately.

Health Care Providers: Write the number of medical or laboratory personnel who will participate with the *Care for Yourself* program. For example, a clinic may have three physicians, two physician assistants, and one registered nurse.

Special Requirements: Provide contact information for laboratories, mammography, radiology or anesthesiology facilities billed separately.

Individual Health Care Provider Name: Print the name of each participating health care provider for whom the facility will bill.

License Number: Include the license/certification number and state for each provider listed.

Signature: A person (CEO or facility manager) authorized to sign legal documents should sign this agreement. This signature verifies the facility information is correct.

Iowa Department of Public Health

Care for Yourself

APPLICATION FOR PROVIDER STATUS

FACILITY (Use official name/DBA)

Name: _____

Address: _____

Telephone: (____) _____ **Fax**: (____) _____ **NPI #** _____

Contact Person _____ **Title**: _____

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

BILLING AGENCY

Name (on claim form): _____

Address: _____

Telephone: (____) _____ **Fax**: (____) _____

Contact Person _____ **Title**: _____

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

SERVICE TYPE(S): Circle all that apply: Clinic Private Practice Hospital Lab Mammography Facility

HEALTH CARE PROVIDERS - Write the number of each who will participate with *Care for Yourself*:

Physician	_____	Surgeon	_____	Pathologist	_____
Physician Assistant	_____	Radiologist	_____	Cytotechnologist	_____
Nurse Practitioner	_____	Radiology technologist	_____	Anesthesiologist/Anesthetist	_____
Nurse	_____	Nurse Midwife	_____	Other (_____)	

SPECIAL REQUIREMENTS

All service providers (i.e. mammography facilities, laboratories, radiologists, etc.) must be *Care for Yourself* participating providers. This will help to ensure that 1) women receive all program services, and 2) providers are reimbursed. *Care for Yourself* staff will verify participation or, if needed, contact the providers listed below.

If you send lipid panels and blood glucose tests to a separate facility, list below the laboratory's contact information. The laboratory will be contacted to pursue an agreement, if necessary.

Laboratories applying for provider status must submit Clinical Laboratories Improvement Act (CLIA) certification issued by Health Care Finance Administration.

Laboratory name, address, phone (if billed separately):

_____

_____

Mammography facility name, address, phone (if billed separately):

_____

_____

Radiology facility name, address, phone (if billed separately):

_____

_____

Anesthesiology facility name, address, phone (if billed separately):

_____

_____

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APPLICATION: *CARE FOR YOURSELF* PROVIDER STATUS

FACILITY NAME _____

FACILITY MAILING ADDRESS _____

_____

PHONE NUMBER _____ **TAX ID NUMBER** _____

INDIVIDUAL HEALTH CARE PROVIDERS

Complete the following for each professional employed (paid by the facility) that may provide services to women in the *Care for Yourself* program.

Name and Title	License/Certificate Number & State	NPI #

SIGNATURE (facility representative authorized to enter into a contract)

The above facility on behalf of its provider group/clinician requests to contract with the Iowa Department of Public Health to provide clinical screenings through the *Care for Yourself* Program.

_____ _____

SIGNATURE **DATE**

(Use as needed to list additional providers)

APPLICATION: *CARE FOR YOURSELF* PROVIDER STATUS

FACILITY NAME _____

TAX ID NUMBER _____ **NPI NUMBER** _____

Name and Title	License/Certificate Number & State	NPI #

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CARE FOR YOURSELF COOPERATIVE AGREEMENT
BETWEEN
THE IOWA DEPARTMENT OF PUBLIC HEALTH AND

_____

Facility Name or Individual (hereinafter referred to as PROVIDER)

_____

Facility Mailing Address **Tax ID Number**

The Iowa Department of Public Health (DEPARTMENT), Division of Health Promotion and Chronic Disease Prevention, Iowa *Care for Yourself* program, has been awarded funds from the Centers for Disease Control and Prevention (CDC) to provide breast and cervical cancer and cardiovascular screenings. Breast and cervical cancer services include clinical breast exam, mammogram, and Pap test, and limited related diagnostic procedures. Cardiovascular screening services include blood pressure, lipids, blood glucose, height and weight. Services are provided to age- and income-eligible women in Iowa. The Iowa *Care for Yourself* Program is designed to reduce breast and cervical cancer morbidity and mortality through early detection and treatment, and to provide early risk factor screening to reduce cardiovascular disease.

The PROVIDER agrees to the terms and conditions set forth below.

I. PROVIDER agrees to abide by the terms and conditions of program guidelines as listed in the Health Care Provider Guide and all requirements of 641 Iowa Administrative Code, Chapter 37 (effective March, 2009). PROVIDER agrees that the DEPARTMENT, at its sole discretion, may modify or alter program guidelines at any time. DEPARTMENT will notify PROVIDER of any changes within thirty (30) days of the change(s).

II. The DEPARTMENT will reimburse the PROVIDER, through its third party payer, for an office visit to include two (2) blood pressure readings, blood lipids and glucose screenings, if appropriate, height and weight measurements, and approved breast and cervical screening and diagnostic services. All services will be reimbursed according to the current Medicare Part B Participating Provider rate, as mandated by the authorizing Federal legislation. The DEPARTMENT will reimburse the PROVIDER for patient co-pay and deductibles up to the designated program rate. (See attached reimbursement schedule for list of approved CPT codes and associated Medicare Part B rates.)

III. The DEPARTMENT will serve as the <u>payer of last resort</u> for uninsured and underinsured program eligible women enrolled in the program prior to or at time of provision of services.
   A. The PROVIDER agrees to accept the program reimbursement rate as payment in full and will not bill individual patients or the DEPARTMENT for any additional costs.
   B. The PROVIDER shall not use DEPARTMENT funds to replace funds from other sources, such as existing federal or state funds which the PROVIDER uses for breast and cervical cancer or cardiovascular screenings and related tracking, follow-up and referral services and over which the PROVIDER exercises discretion.
   C. All provider services pursuant to this provider agreement shall be performed to the satisfaction of the DEPARTMENT, and in accordance with all applicable federal, state, and local laws, ordinances, rules and regulations.

IV. Reimbursement will NOT be made for services performed until the Cooperative Agreement is signed by the PROVIDER and the DEPARTMENT, or for services performed for women. Services provided to an individual program participant prior to the signature and date on the Annual Enrollment/Assessment form, will not be reimbursed.

V. SUSPENSION OR TERMINATION

A. The DEPARTMENT or PROVIDER may terminate this agreement at any time, with or without cause, upon sixty (60) days written notice to the other party. In the event of such, termination, PROVIDER shall be entitled to payment for services satisfactorily performed.

B. Continuation of this agreement beyond the last day of the program fiscal year is contingent upon continued award of funds from the Centers for Disease Control and Prevention (CDC). If these funds are not awarded, the DEPARTMENT shall immediately notify PROVIDER in writing sixty (60) days prior to termination.

C. This agreement may be temporarily suspended upon immediate notice if the DEPARTMENT determines that funds allocated for screening will soon be, or have been, expended. The agreement will automatically be resumed when additional funding is obtained, unless the PROVIDER notifies the DEPARTMENT in writing that the PROVIDER does not wish to resume participation in the program, at which point this agreement shall be deemed terminated.

VI. ACCOUNTS AND RECORDS

A. The PROVIDER shall maintain accurate, current, and complete records of the financial activity of this contract, including records which adequately identify the source and application of funds. Cash contributions made by the PROVIDER and third party in-kind (property or service) contributions shall be verifiable from the PROVIDER's records. These records must contain information pertaining to contract amount, obligations, unobligated balances, assets, liabilities, expenditures, income and third-party reimbursements.

B. The PROVIDER shall retain all medical records for a period of six (6) years from the day the PROVIDER submits its final expenditure report; or in the case of a minor patient or client, for a period of one (1) year after the patient or client attains the age of majority, whichever is later.

C. The PROVIDER shall maintain the confidentiality of all records of the project in accordance with state and federal laws, rules, and regulations, and the terms of section 9 of this Cooperative Agreement.

VII. INSURANCE: The PROVIDER shall procure and maintain such insurance as is required by applicable federal and state law and regulation. Such insurance should include, but not be limited to, the following: liability insurance, fidelity bonding of persons entrusted with handling of funds, workers compensation, unemployment insurance, and professional liability.

VIII. INDEMNIFICATION: The PROVIDER and its successors and assignees agree to indemnify and hold harmless the State of Iowa and the DEPARTMENT and its officers, employees, agents, and volunteers from any and all liabilities, damages, settlements, judgments, costs and expenses, including the reasonable value of time spent by the Attorney General's Office and the costs and expenses and reasonable attorney fees of other counsel required to defend the DEPARTMENT or the State of Iowa, related to or arising from any of the following:

A. Any violation of this contract.

B. Any negligent, intentional, or wrongful act or omission of the PROVIDER, its officers, employees, agents, board members, providers or subproviders, or any other person in connection with this program.

C. Any infringement of any patent, trademark, trade dress, trade secret, copyright, or other intellectual property right.

D. The PROVIDER's performance or attempted performance of this contract.

E. Any failure by the PROVIDER to comply with all federal, state, and local laws and regulations.

F. Any failure by the PROVIDER to make all reports, payments, and withholdings required by federal and state law with respect to social security, employee income, and other taxes, fees, or costs required by the PROVIDER to conduct business in the State of Iowa.
G. The death, bodily injury or damage to property of any enrollee, agent, employee, business invitee or business visitor of the PROVIDER or any of its subproviders.
H. Any failure by the PROVIDER to adhere to the confidentiality provisions of this contract.

IX. CONFIDENTIALITY

A. Release of Contract Information to the DEPARTMENT: The PROVIDER agrees to provide to the DEPARTMENT, upon request, all records related to the contract including, but not limited to, client records, statistical information, board and other administrative records, and financial records, including budget, accounting activities, financial statements, and the annual audit in accordance with Code of Federal Regulations, Title 45.
B. Confidentiality of Client Records: The PROVIDER's policies and procedures shall provide that records regarding the identity, diagnosis, prognosis, and services provided to any client in connection with the performance of the contract are confidential and that such records shall be disclosed only under the circumstances expressly authorized under state or federal confidentiality laws, rules or regulations.
C. Security of Client Files and Data: The PROVIDER's employees, agents, and subproviders shall be allowed access to confidential records only as necessary for the performance of their duties related to the contract and in accordance with the policies and procedures of the custodian of the records. The PROVIDER shall maintain policies and procedures for safeguarding the confidentiality of such data, and may be liable civilly or criminally under state or federal confidentiality laws, rules or regulations for the unauthorized release of such information.
D. Unauthorized Disclosure: The PROVIDER shall maintain the confidentiality of all records related to this contract in accordance with state and federal laws and regulations. The PROVIDER shall protect from unauthorized disclosure all confidential records and data, including but not limited to the names and other identifying information of persons receiving services pursuant to this contract, except for statistical information not identifying any client. The PROVIDER shall not use such identifying information for any purpose other than carrying out the PROVIDER's obligations under this contract.

X. QUALIFICATIONS OF STAFF

A. The PROVIDER shall be responsible for assuring that all persons, whether they are employees, agents, subproviders or anyone acting for or on behalf of the PROVIDER, are properly licensed, certified or accredited as required under applicable state law and the Iowa Administrative Code. The PROVIDER shall provide standards for service providers who are not otherwise licensed, certified or accredited under state law or the Iowa Administrative Code.
B. PROVIDER'S CERTIFICATION REGARDING SUSPENSION AND DEBARMENT: The PROVIDER certifies pursuant to 31 CFR part 19 that neither it nor its principles are presently disbarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract by any federal department or agency. The PROVIDER further agrees to comply with the regulations implementing executive order 12549 regarding debarment and suspension.

XI. CONTRACT ADMINISTRATION

A. STATUS OF PROVIDER: The PROVIDER shall at all times be deemed an independent contractor. The PROVIDER, its employees, agents, and any subproviders performing under this contract are not employees or agents of the State of Iowa or any agency, department, or division of the state. The PROVIDER shall be responsible for all its withholding taxes, social security, unemployment, worker's compensation and other taxes and shall hold the DEPARTMENT harmless for any claims for same. If the PROVIDER is a non-profit organization or affiliated with a government organization, the PROVIDER shall file all required state and federal reports to maintain such status.

B. COMPLIANCE WITH THE LAW: The PROVIDER, its employees, agents, and subproviders shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, and orders when performing the work and services under this agreement, including without limitation the following: all laws applicable to the prevention of discrimination in employment, all laws applicable to the nondiscriminatory provision of services or benefits, all laws applicable to accessibility of facilities, and all laws applicable to the use of targeted small businesses as subproviders or suppliers. The PROVIDER, its employees, agents, and subproviders shall also comply with all federal, state, and local laws regarding business permits and licenses that may be required to carry out the work and services to be performed under this agreement.

XII. PROVIDER'S CERTIFICATION REGARDING LOBBYING

A. The PROVIDER certifies that no Federal appropriated funds have been paid or will be paid, by or on behalf of the PROVIDER, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

B. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any Federal contract, grant, loan, or cooperative agreement, the PROVIDER shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

C. The PROVIDER shall require that the language of this section be included in the award documents for all subawards at all levels (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

D. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code of Federal Regulations. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

XIII. PROVIDER'S CERTIFICATION REGARDING BROKERING

A. The PROVIDER certifies that no person or selling agency has been employed or retained to solicit and secure this contract upon an agreement or understanding for commission, percentage, brokerage, or contingency excepting bona fide employees or selling agents maintained by the PROVIDER for the purpose of securing business. For breach or violation of this certification, the DEPARTMENT shall have the right to terminate this contract without liability, or in its discretion, to deduct from the contract price or to otherwise recover the full amount of such commission, percentage, brokerage, or contingency.

XIV. PROVIDER'S CERTIFICATION REGARDING A DRUG FREE WORKPLACE

A. The PROVIDER shall provide a drug free workplace in accordance with the Drug Free Workplace Act of 1988 and all applicable regulations. The PROVIDER is required to report any conviction of employees under a criminal drug statute for violations occurring on the PROVIDER's premises or off the PROVIDER's premises while conducting official business. A report of a conviction shall be made to the DEPARTMENT within five (5) working days after the conviction.

XV. PROVIDER'S CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development

services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

B. The PROVIDER certifies that it will comply with the requirements of the Act and the provisions of Iowa's Smokefree Air Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

C. The PROVIDER agrees that it will require that the language of this certification be included in any subcontract or subaward that contains provisions for children's services and that all subrecipients shall certify accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1,000 per day.

XVI. SUPERSEDES FORMER CONTRACTS: This contract supersedes all prior contracts between the DEPARTMENT and the PROVIDER for work and services provided in connection with this contract.

XII. AMENDMENTS: Any changes to this agreement will be valid only if made in writing and accepted by all parties to this agreement.

XVII. EFFECTIVE DATES: This agreement shall be in effect from PROVIDER'S receipt of this contract signed by DEPARTMENT, for a term of six (6) years, or until terminated in accordance with Section V above.

_____	_____
Julie McMahon, Director Iowa Department of Public Health Division of Health Promotion and Chronic Disease Prevention	Provider Signature
_____	_____
Date	Date

For office use only: Facility # _____

Care for Yourself Program

BILLING FOR SERVICES

The *Care for Yourself (CFY)* program has contracted with Provider Claim Systems, a division of North Iowa Community Action Organization, to process claims and reimburse health care providers for program services. Provider Claim Systems processes claims and issues checks for the *Care for Yourself* program.

CLAIMS SUBMISSION

Send claims to: Provider Claim Systems
PO Box 1608
Mason City, IA 50402-1608

OR: Local *CFY* program (check with your *CFY* program coordinator)

CLAIM FORMS

Originals of the HCFA 1500 and the UB 92 are the only accepted forms. The following information must be included for a claim to be processed:

- Participant name and address
- Participant Social Security Number
- Participant Birth date
- Date of service
- CPT code for each approved service(s) provided
- Charge for service
- Facility name, address and Tax ID number
- If insurance is involved, complete the following:
    - For the HCFA 1500, Boxes 28 (Total Charge), 29 (Amount Paid), & 30 (Balance Due)
    - For the UB 92, Boxes 54 (Prior Payments) and 55 (Est. Amount Due)

REIMBURSABLE SERVICES

The *Care for Yourself* program incorporates breast and cervical cancer and cardiovascular risk factor screenings. Breast and cervical cancer services include clinical breast exam, mammogram, Pap test and limited related diagnostic procedures. Program cardiovascular screening services include blood pressure, lipids, blood glucose, and height and weight measures. Codes billed, but not listed on the Reimbursement Schedule, will be denied.

The Reimbursement Schedule is part of this document. Only codes listed on the form will be reimbursed at the rates listed. The Iowa *Care for Yourself* program is required by Federal law to reimburse at state of Iowa Medicare Part B Participating Provider rates. These rates change each year. The Reimbursement Schedule is revised annually to reflect the new rates. A copy of the Schedule is sent to each provider facility but can also be found on the *CFY* program website http://www.idph.state.ia.us/CFY/Providers.aspx, click on *CFY* Reimbursement Schedule July 2012

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HEALTH CARE PROVIDER RESPONSIBILITIES

1. Verify that the woman is enrolled in the Iowa *Care for Yourself* Program by asking for her *Care for Yourself* participant card.
2. Report all data as requested by the *Care for Yourself* Program Coordinator.

CLAIMS REIMBURSEMENT REPORT

1. *Care for Yourself* is the payer of last resort. An Explanation of Benefits (EOB) must be obtained from an insurance company when appropriate. **Do not submit the EOB to Provider Claim Systems.** If reimbursement is received from an insurance company, the health care provider's billing agency is responsible for entering on the claim form the amount of reimbursement received, and for **not double billing.** Provider Claim Systems will reimburse for co-pay and deductibles up to the amount indicated on the Iowa Care for Yourself Reimbursement Schedule. **Under no circumstances may the woman be billed for Care for Yourself covered services.**
2. Submit the claim forms to the billing agency, Provider Claim Systems, PO Box 1608, Mason City, IA 50402-1608, or to the local program, with complete and accurate information.

When claims payment is received, a list is provided of women for whom reimbursement is being made. The list will include the participant's name, date of birth, date of service, the CPT code, and amount paid.

QUESTIONS

Questions about your claims should be directed to Provider Claim Systems at **(800) 547-6789** or the local *Care for Yourself* coordinator.

Questions about your Cooperative Agreement should be directed to the Iowa Department of Public Health, *Care for Yourself* at **1-800-369-2229**.