Unmet Medical Request

Facility Name
Facility Address
Facility Address
Facility Phone Number

This is an unmet medical request for ***Resident Name*** at ***Facility Location*** to include the months prior to Medicaid approval **Please send a copy of the approved unmet medical agreement to the facility.** Please let us know if there are any questions!
Thank you! -***Facility Name***

Date ***Todays Date***

Resident ***Resident Name***
Medicaid ID # **??????A**

Facility Signature **Resident or Representative Signature** ***Amount Due*** **$ -**

From	*Through*	*Days*	*Description*	*Rate*	*Amount*
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					$ -
			Total Unmet Medical Requested		**$ -**

Unmet Medical Expense Directions:

1. Fill in facility information at top of form.
2. Fill in resident and facility name in paragraph below facility information.
3. Complete the date, resident name, and state ID to the right of the paragraph.
4. Itemize room and board and medically necessary ancillary charges.
5. Cable, hair care, personal items, phone, guest meals, or any other charges that are not considered medically necessary cannot be included on this request.
6. Have facility representative and resident or resident representative sign and submit to DHS via one of the options below:

Fax: 515-564-4040

Email: facilities@dhs.state.ia.us

Mail:
Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E Kanesville Blvd.
Council Bluffs, IA 51503-4470

Please contact CFEU at 877-344-9628 if you would like the Excel version of this form.