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

Gerd W. Clabaugh, MPA
Director

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Governor

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Lt. Governor

Iowa *Care for Yourself* - BREAST AND CERVICAL CANCER PROGRAM
APPLICATION FOR HEALTH CARE FACILITY & HEALTH CARE PROVIDER ENROLLMENT

SERVICE TYPE(S): Check all that apply: ☐ Clinic ☐ Private Practice ☐ Hospital ☐ Lab ☐ Mammography

Tax ID # _____ **NPI #** _____

FACILITY (USE official name/DBA) This is the location where services will be performed

Facility Name_____

Facility Mailing Address_____

Facility Physical Address (If different**)** _____

Facility Telephone _____ **Facility Fax** _____

Contact Person _____ **Title** _____

Telephone _____ **E-mail Address** _____

BILLING AGENCY –Address where payments should be mailed

☐ **Check the box if the billing agency address is the same as the Facility Mailing Address.**

☐ **Check the box if the billing agency NPI# is the <u>same</u> as the Facility NPI#.** If different please list # below:

Billing Agency NPI # _____

Billing Agency Name _____

Billing Agency Mailing Address _____

Billing Telephone _____ **Billing Fax** _____

Contact Person _____ **Title** _____

Telephone _____ **E-mail Address** _____

SPECIAL REQUIREMENTS: All health care providers and facilities must be enrolled in the Care for Yourself – Breast and Cervical Cancer program to receive reimbursement for services.

Identified facilities listed below need to complete a separate Cooperative Agreement and Application for Health Care Facility & Health Care Provider Enrollment if not associated with the same Tax ID Number listed above. This will help ensure participants receive program services without being billed, and health care facilities and providers receive appropriate reimbursement.

Laboratory name, address, phone

_____

Mammography name, address, phone

_____

Radiology name, address, phone

_____

Anesthesiology name, address, phone

_____

PARTICIPATING CFY – BCC HEALTH CARE PROVIDERS

FACILITY Tax ID #		
NAME(S) – Print the name of each participating **health care provider** that may bill the program. Include **credentials.**	**LICENSE/CERTIFICATE NUMBER**	**NPI NUMBER**
Example: Mary Jo Smith, DO	0415	0123456789

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

EFFECTIVE DATES: This agreement shall be in effect from CORPORATION/LEAD FACILITIES receipt of this contract signed by the DEPARTMENT for a term of six (6) years, or until terminated.

_____
Authorized Corporation/Lead Facility Signature

_____
Date

For office use only: Facility # _____