



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 (____) _____ Email 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 same 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 (____) _____ Email Address _____

SPECIAL REQUIREMENTS: All health care providers and facilities must be enrolled in the Care for Yourself - Breast and Cervical Cancer (BCC) 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 _____

