Iowa Care for Yourself
Breast and Cervical Cancer Program (BCC)

Service Facility Application

FACILITY INFORMATION

Please complete based on the location where services will be performed using the official name
Fill out this form for any hospital, clinic, or lab that could perform and bill services to the program.

Tax ID #	**NPI #** *(Box 33A of HCFA 1500)*
Service Facility Name *(Needs to match box 32 of HCFA 1500)*	
Physical address: Street -	
City, State, ZIP Code -	
Mailing address (if different) Street -	
City, State, Zip Code -	
County where facility is located	**Phone number**
Facility contact name	**Contact phone number**
Contact e-mail address	

Please check all service types that apply for this facility

☐ Ambulatory Service ☐ FQHC ☐ Lab/Pathology ☐ Mammography/Radiology ☐ Pharmacy ☐ Specialist

Complete the section below if this facility has merged with or been bought out from a different facility.

Previous facility name	Previous tax ID #	Previous facility address

BILLING INFORMATION

Complete based on the address where payments should be mailed. MUST MATCH CLAIM FORM

Reimbursement of claims will only be processed up to one year (12 months) from the date of service. Claims exceeding the 12-month period from the date of service will be denied.

Billing Agency (Provider) Name *(Needs to match box 33 of HCFA 1500)*	
Mailing Address Street -	
City, State, Zip Code -	
Billing contact name	**Phone number**
Contact e-mail address	

Authorized Facility Signature	**Date**
Sign	
Print	

Please send completed forms via email or fax to: Attn: Iowa Screening Programs – Gena
Email: gena.hodges@idph.iowa.gov or Fax: 515-242-6384 (If you have questions call Gena at: 515-281-4909)

UPD: 1.13.20