Clear Form | Print Form

EDI Support Services **PO Box 6729** **Fargo, ND 58108-6729**	**Phone: (800) 967-7902** **Fax: (701) 277-7850**

Complete the form and select the Print Form button. Once printed, obtain the appropriate signature and mail or fax the form to EDISS.

The information you provide on this access request form is used to obtain a login ID and password to gain access to the Iowa Medicaid Enterprise Web Portal for conducting real-time eligibility and claims status requests on behalf of a specific provider or facility. If you have questions regarding the correct completion of this form, please contact EDISS for assistance.

☐ I am requesting a new user ID or access to additional provider numbers.

☐ I am requesting termination of my user ID. My user ID is: _____

USER INFORMATION

1. Do you currently have access to the Iowa Medicaid Enterprise (IME) Web Portal for conducting real-time requests? Select Yes or No, and complete the appropriate information.

☐ Yes, I have access to the IME Web Portal. My Current user ID is:_____.

☐ No, I do not have access to the IME Web Portal. Please set up access for:

First Name: _____ M.I. _____ Last Name: _____

Mother's Maiden Name: _____

☐ 270/271 - Health Care Eligibility Benefit Inquiry and Response

☐ 276/277 - Health Care Claim Status Request and Response

Note: EDISS will only set up the transaction(s) for which the proper paperwork is currently on file with EDISS. If you have not completed the registration paperwork for the transaction you are requesting above, this form will not be accepted by EDISS.

2. Complete the contact information for the **user** requesting access to the IME Web Portal.

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ **Fax Number: _____

Email: _____

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FACILITY INFORMATION

3. Fill in the blanks with the information for the provider/facility for which you are requesting access to the IME Web Portal for conducting real-time eligibility and/or claim status requests on their behalf.

Facility Name: _____

NPI Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Contact: _____

Phone Number: _____ **Fax Number: _____

Email: _____

**By providing your fax number, you are consenting that your fax machine is located in a secure area that is not accessible by anyone who is not authorized to view confidential information.

4. A signature of the IME Web Portal user and the provider or authorized member of the organization is required for this form. The form with the valid signatures must be mailed or faxed to EDISS to avoid any interruptions in your ability to conduct real-time requests on behalf of a provider/facility.

By signing, the user agrees to:

1. Be responsible for all activities logged under the user ID.
2. Not share or exchange the user ID or password.
3. Report any suspected misuse of the user ID to Electronic Data Interchange Support Services (EDISS).
4. Use the system to perform tasks related to Iowa Medicaid Enterprise Web Portal functions only.

Non-compliance with the above is considered to be unacceptable behavior, which is cause for EDISS to revoke access.

As the IME Web Portal User, I hereby agree to the terms and conditions outlined above and request access to the IME Web Portal be granted.

Signature _____

Type Name: _____

Title: _____ Date: _____

As the provider or authorized member of the organization, I hereby authorize the IME Web Portal user listed above to conduct Eligibility and Claim Status requests on the behalf of this provider/organization.

Signature _____

Type Name: _____

Title: _____ Date: _____