Provider Enrollment Manual

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Before Starting an Application

To navigate through the Provider Enrollment Portal, please have the latest version of one of the following browsers installed on the personal computer (PC).

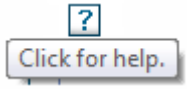
- Internet Explorer Version 9.0 and later
- Firefox
- Safari
- Google Chrome

More Information on a Field

Throughout the application a red asterisk (*****) next to a field indicates the field could either be required information or optional, if the user begins entering data.

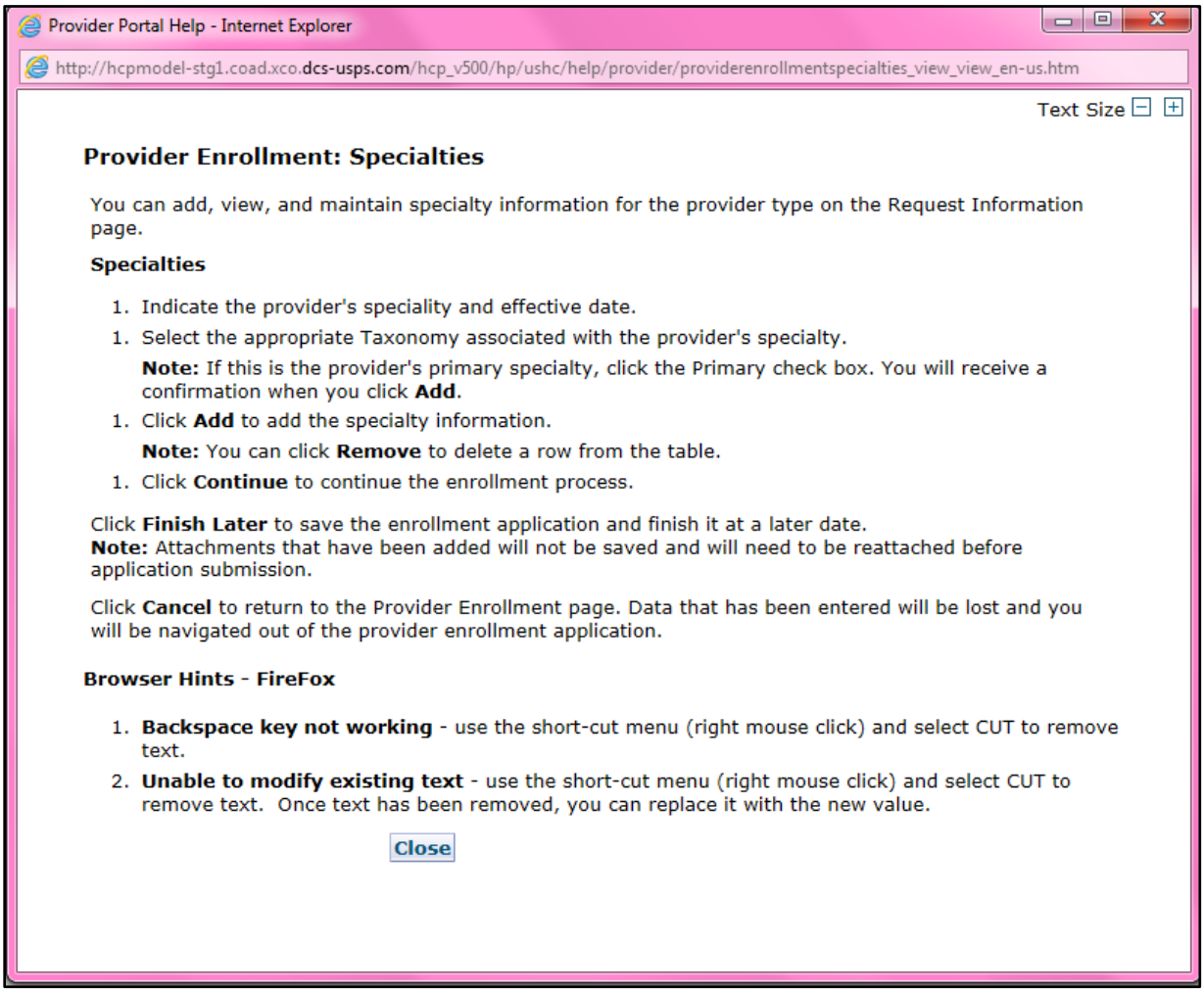
In certain fields, additional information can be found by hovering the cursor over the symbol. Hovering over this symbol will open a gray box that will give more information about the field. The gray information box will disappear when the cursor is moved.

Help Feature on Each Panel

Throughout the application there is a question mark 

symbol towards the top right corner of each panel. Clicking on it will open a dialog help window specific to the screen the user is currently in:

The example below displays the Specialties Help panel. The screen may look similar to the following:



Provider Enrollment Manual Overview

Provider Type, Enrollment Type and Enrollment Requirements

Enrollment requirements will vary depending on the provider type & enrollment type. Having the required enrollment information for the provider and enrollment type available prior to beginning the application will help expedite the enrollment process.

Visit the Information by Provider Type web page to view additional enrollment requirements for the provider type. Visit the Provider Enrollment Types web page to view the allowable provider types for each enrollment type. The following section list the enrollment requirements for each enrollment type.

Enrollment Types

Individual within a Group

This enrollment type is for an individual that renders services but does not bill Colorado Medicaid directly. These providers must be associated with a Group that submits claims on their behalf.

- Must use SSN as the Tax ID Type
- Must associate to at least one "Group" provider enrollment type
- The group that the individual will affiliate to must have an approved enrollment before the individual can enroll.

Group

This enrollment type is a clinic or practice that will submit claims on behalf of one or more practitioners enrolled as an Individual within a Group. Income is reported to the (Internal Revenue Service (IRS) under the business EIN.

- Must use EIN as the Tax ID Type
- Billing/direct pay entity
- Must have at least one enrolled "Individual within a Group" practitioner associated. (This association is indicated on the "Individual within a Group" application). Associations may be added, removed, or changed after enrollment by logging in to the provider web portal.

Billing Individual

This enrollment type is for an individual who receives direct payment for services rendered and submits claims for his/her own services. Income is reported to the IRS under the individual's SSN.

- Must use SSN as the Tax ID Type
- Billing/direct pay entity

Individual Who Wants to Use EIN for Enrollment

This is a common scenario for individuals, such as physicians, who own their own practice. **Even if the individual is the only practitioner**, if using an EIN for billing, this is a business. In order to enroll the business, a group enrollment type application must be completed. In this example, a 'Group' enrollment

type application would need to be completed as a provider type '16 – Clinic Practitioner Group. **Must use EIN as the Tax ID Type and enter the group EIN tax ID.**

After the physician in this example has submitted an application for his/her business and it has been approved for enrollment, he/she would **also need to submit a second application as an Individual Within a Group with a provider type of "Physician" for themselves as the rendering practitioner.** While completing the "individual Within a Group" application, the physician will indicate that they are affiliated to the group that was enrolled for the business. **Must use SSN as the Tax ID Type and enter the individual SSN tax ID.**

This will allow the individual physician to bill under their business EIN and render services to members via the SSN enrollment.

Facility

This enrollment type is for an entity that will be submitting claims for services rendered. An associated Individual within a Group provider enrollment type is **not** required.

- EIN only
- Billing/direct pay entity

Atypical

An Atypical provider renders non-medical services. These providers may include, but are not limited to, Home and Community-Based Waiver Services (HCBS) providers, Managed Care Organizations (MCOs) and Regional Accountable Entities (RAE).

- Enrollment requirements vary. Visit the Information by Provider Type web page to view enrollment requirements.
- SSN or EIN tax ID type may be used depending on provider type requirements.

Ordering, Prescribing and Referring (OPR)

This enrollment type is for individuals who **only** order, prescribe or refer items or services covered by Health First Colorado (Colorado's Medicaid Program) for Health First Colorado members. These physicians and other professionals are not enrolled as an Individual within a Group or a Billing Individual and will not submit claims for payment of services rendered.

- SSN only

Program of All-Inclusive Care for the Elderly (PACE)-Only Subcontractor

This enrollment type is for an entity or individual that has a valid contract with a participating PACE Organization. Once the PACE-Only Subcontractor is enrolled, the associated PACE Organization may submit PACE encounter claims listing the sub-contractor's provider number and information.

- SSN or EIN tax ID type may be used depending on provider type requirements.
- The PACE Subcontractor Participation Attestation Form is required for this enrollment type.
- PACE-Only Subcontractors are exempt from the following enrollment requirements:
    - Electronic Funds Transfer (EFT) Enrollment
    - Addendums
    - Disclosures
    - Fingerprinting

  - Submission of licensure, certification, or insurance
  - Application fee
  - Provider Participation Agreement
  - Site Visits
- PACE-Only Subcontractors cannot register for the Provider Web Portal and must contact the Provider Services Call Center to update their provider information or disenroll.

Additional Required Information

National Provider Identifier (NPI) – The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. The NPI is a 10-digit numeric identifier. Not all provider types require an NPI. To apply for an NPI, visit the National Plan & Provider Enumeration System (NPPES) website.

- To determine if an NPI is required, visit the Information by Provider Type web page.
- Refer to the list below to verify which type of NPI is required based on the enrollment type.

Enrollment Type	Requirement
Group	Organizational NPI & associated zip code +4
Facility	Organizational NPI & associated zip code +4
Individual within a group	Individual NPI & associated zip code +4
Billing individual	Individual NPI & associated zip code +4
Ordering-Prescribing-Referring	Individual NPI & associated zip code +4
Atypical provider	*NPI may or may not be required
PACE-Only Subcontractor	*NPI may or may not be required

*Not all Atypical providers require an NPI. Visit the Information by Provider Type web page or Information by HCBS Specialty web page to determine whether an individual or organizational NPI is needed for the selected Atypical enrollment.

Provider Taxonomy Codes – The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions designed to categorize the type, classification, and/or specialization of health care providers.
Use the Search NPI Records tool to see the taxonomy codes that were used when originally applying for the NPI.

Address Information

Service Address – This is the location where services are rendered. This address populates the Find a Doctor directory used by members. The email address associated with the service location is used to send provider communications such as newsletters and bulletins.
(Each service address for an organization requires a separate application and unique NPI.)

Mailing Address – This address is where paper Prior Authorization Request (PAR) letters are sent if the provider is not receiving PAR letters electronically.

Billing Address – This address is where paper checks and remittance advice statements are sent if the provider is not receiving them electronically.

Federal Employer Identification Number (EIN) vs Social Security Number (SSN) – A EIN is used to identify a business entity; an SSN is used for individuals.

Provider License Number (if applicable) – This is the identification number assigned by licensing agencies.

Completed W-9 Form (must be signed & dated within the last 6 months)

Enrollment Type	Requirement
Group	W-9 with EIN
Facility	W-9 with EIN
Atypical provider	W-9 with EIN or SSN (as applicable)
Billing individual	W-9 with SSN
Individual within a group	not required
Ordering-Prescribing-Referring	not required
PACE-Only Subcontractor	not required

Malpractice and Liability Insurance Information – Insurance information must be entered on the application by all provider types. A copy of the current insurance face sheet is required for Nursing Facilities. (All other provider types are not required to attach a copy.)

Banking Information

Electronic Fund Transfers (EFT) is required for payments. A copy of a voided check or a bank letter that is signed and dated within 6 months of application submission must be uploaded to the application on the Attachments & Fees panel.

- Voided checks must be pre-printed. Checks cannot be handwritten or temporary checks.
- The printed name on the voided check must match either the legal name or the doing business as (DBA) name entered in the application.
- The routing number on the voided check must match the routing number entered on the EFT panel.
- The bank account number listed on the voided check must match the bank account number entered on the EFT panel.
- Deposit slips are not acceptable.

If a bank letter is attached in lieu of a voided check:

- The bank letter must be printed on the bank's letter head. It cannot be handwritten.
- The bank letter must be signed by a bank representative and dated within 6 months of the application submission.

- The account holder name must match the legal or DBA name in the application.
- The routing number listed on the bank letter must match the routing number entered in the EFT panel.
- The bank account number listed on the bank letter must match the bank account number entered in the EFT panel.

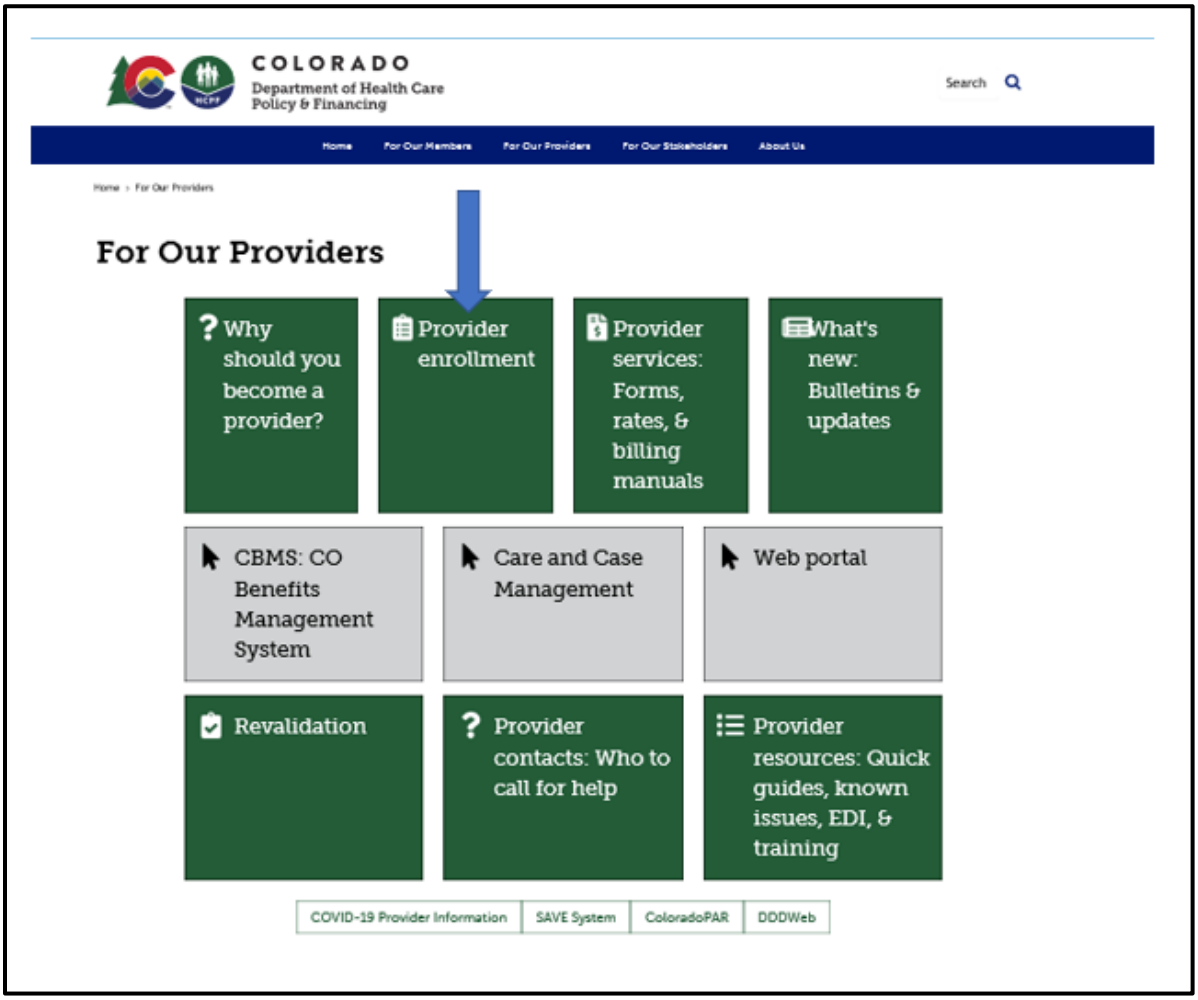
Ownership/Controlling Interest and Conviction Disclosure Information

For each person or entity with an ownership or control interest of 5% or more in the enrolling provider (including a Board of Directors with 0% ownership) the following information is needed:

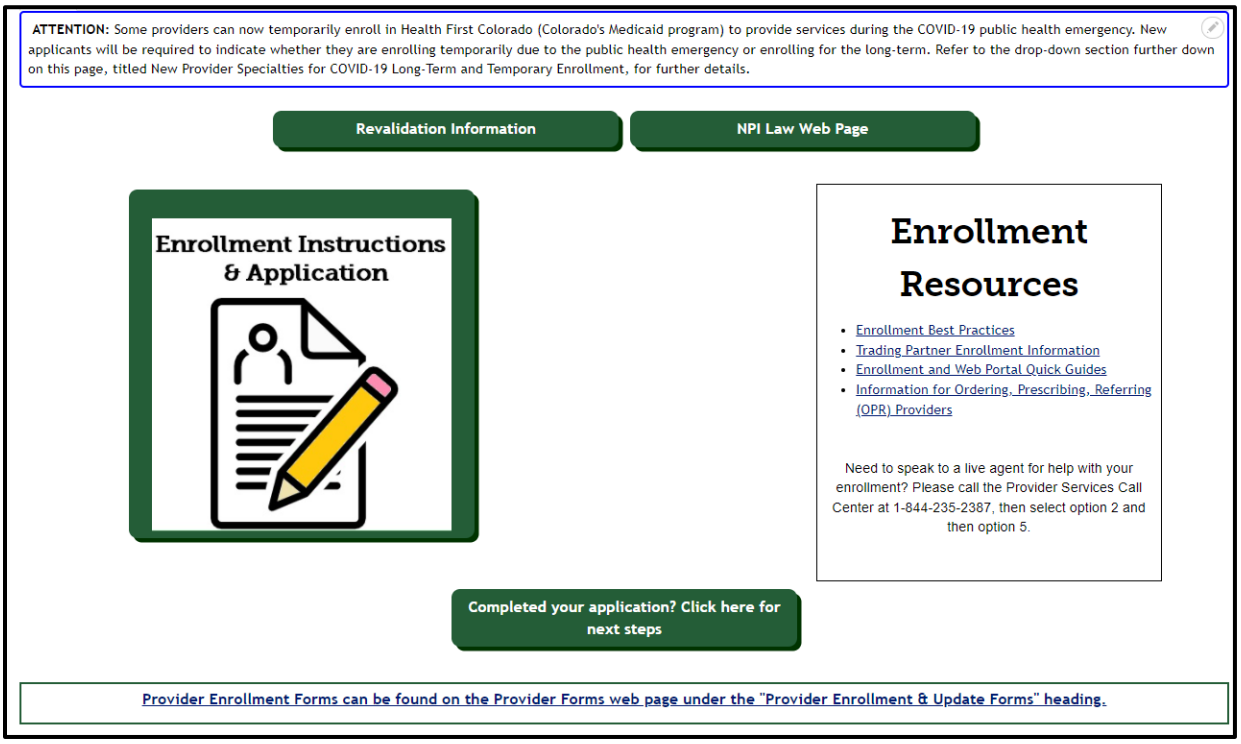
- Name
- Address
- Federal employer ID number (EIN) or Social Security Number (SSN)
- Date of birth (DOB) if an individual

Accessing the Provider Enrollment Portal

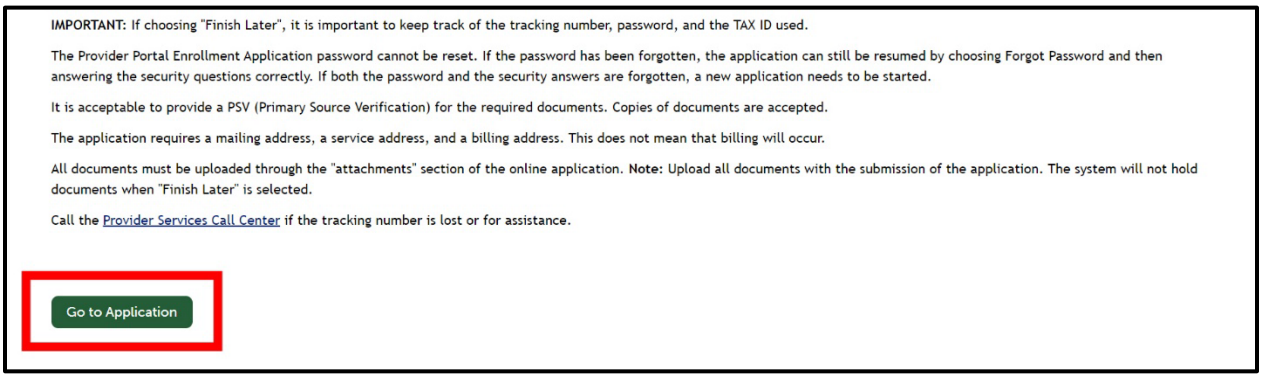
To access the Provider Enrollment Portal, open an internet browser, and visit the [For Our Providers web page](). Click “Provider enrollment”.



Clicking on "**Provider enrollment"** brings up the Provider Enrollment web page. Click the Enrollment Instructions & Application button. **Read through the "Common Reason Enrollment Applications Are Returned to Providers" instructions and review each step to determine the Provider Type and Enrollment Type.**



When ready to begin, click the "Go to Application" button at the bottom of the Enrollment Type web page.

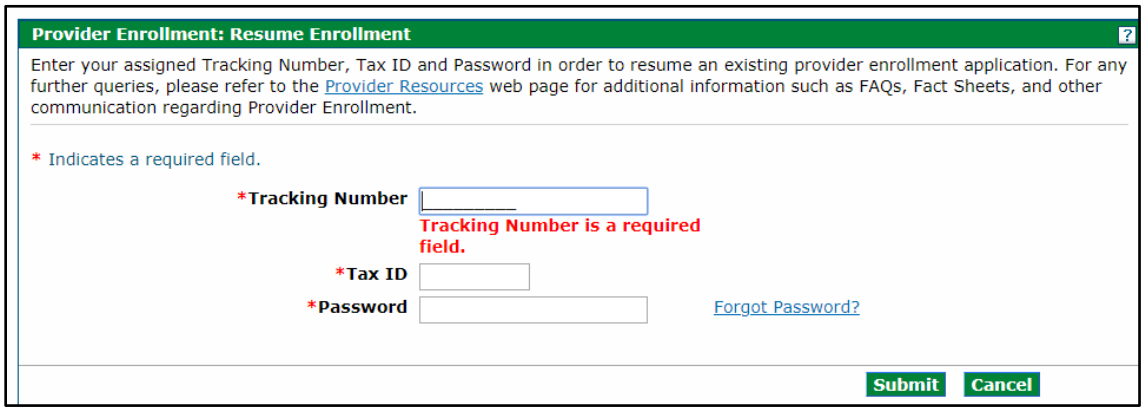


After clicking "**Go to Application**", the panel below will be displayed. Click the "**Enrollment Application**" link to begin the enrollment.

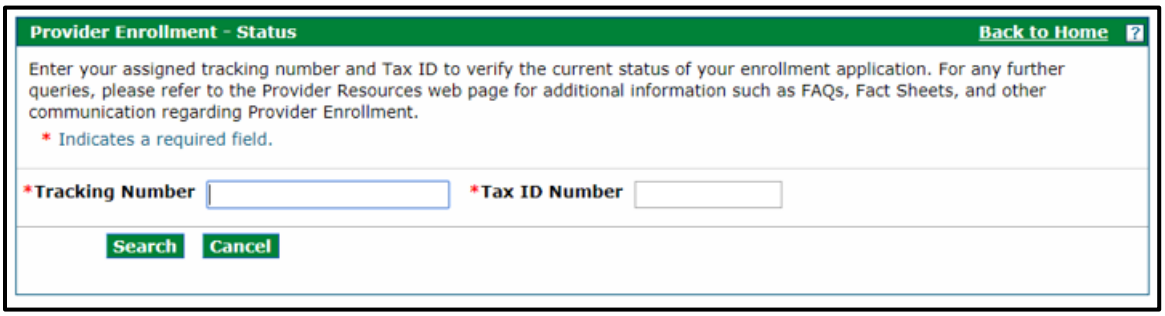
Provider Enrollment Home Panel

The additional links on this panel are:

- **Resume Enrollment:** This allows the user to finish an enrollment application that was started earlier and saved or open an application that has been returned for correction. The user will need the Application Tracking Number (ATN), the Tax ID enrolling on the application and the password that was set up when submitting or saving the application.



- **Enrollment Status:** This allows the user to check the status of a previously submitted application. The user may also view any comments left by reviewers here. The user will need the Application Tracking Number and the tax ID entered on the application.



With a successful login, the user will see the status of the application and reviewer comments. This is also where the user will go if they disagree with a denied enrollment and need to submit a grievance. Refer to the File a Grievance section for instructions on how to file a grievance.

Completing the Application

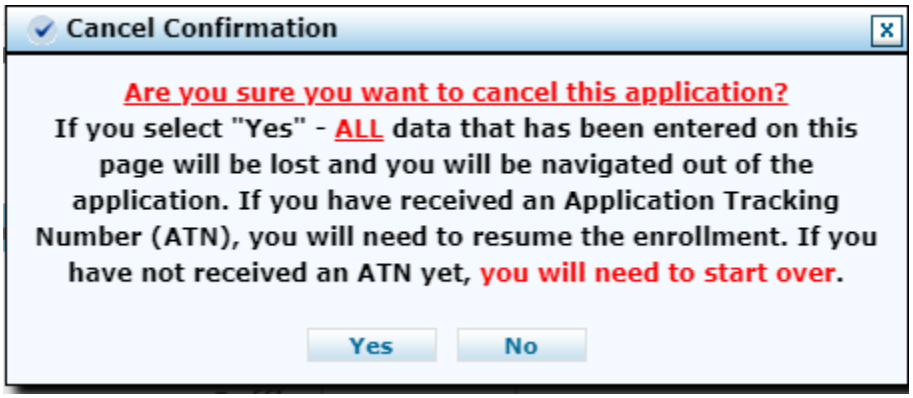
The Provider Portal utilizes an autosave feature to automatically save entered data in the enrollment process. While completing the application, the user will see three (3) buttons available at the bottom of each panel.

These buttons allow the user to:

Continue – Continue to the next panel of the enrollment application. The autosave process is initiated after entering data on the Request Information panel and clicking Continue. Each click of this button on subsequent panels will automatically save the data entered on the current panel.

Cancel – Stops the application process. If an Application Tracking Number (ATN) has been generated, this button will prompt the end of the application process without saving the data on the current panel (data entered on prior panels has already been saved). If an ATN has not been generated yet, this button will prompt the end of the application process **without saving the data**. Note that a confirmation notification to cancel will appear before the user is allowed to proceed.

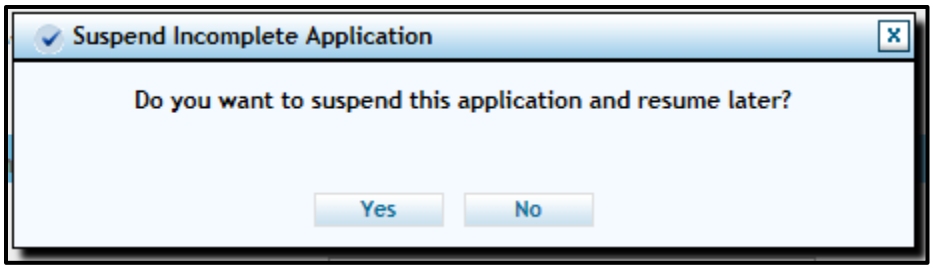
The Cancel Confirmation screen shown below will appear. If "**Yes**" is selected, all data entered on this and any previous panels will be lost if an ATN has not been generated.



Finish Later – Saves the information and allows the user to come back to the application later.

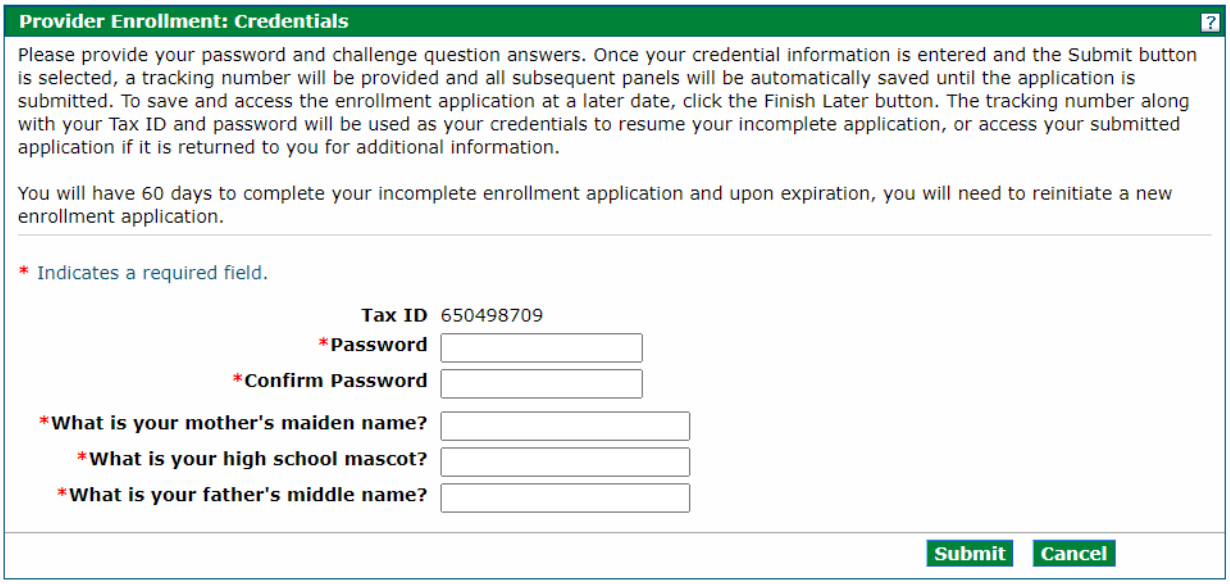
The following box will appear:

Suspend Incomplete Application Pop Up



Select "**No**" and the user will return to the application process. Select "**Yes**" and the following Provider Enrollment Credentials panel will appear:

Provider Enrollment: Credentials Panel



Password – Select a password to use for the enrollment process. This field is required for all providers saving their application. This user-defined password must be between 8-20 alphanumeric characters.

Confirm Password – Confirm the password to use for the enrollment process. This field is required for all providers saving their application.

What is your mother's maiden name? – Enter mother's maiden name. This field is required for all providers saving their application. This user-defined response can have a maximum of 50 alphanumeric characters.

What is your high school mascot? – Enter a high school mascot. This field is required for all providers saving their application. This user-defined response can have a maximum of 50 alphanumeric characters.

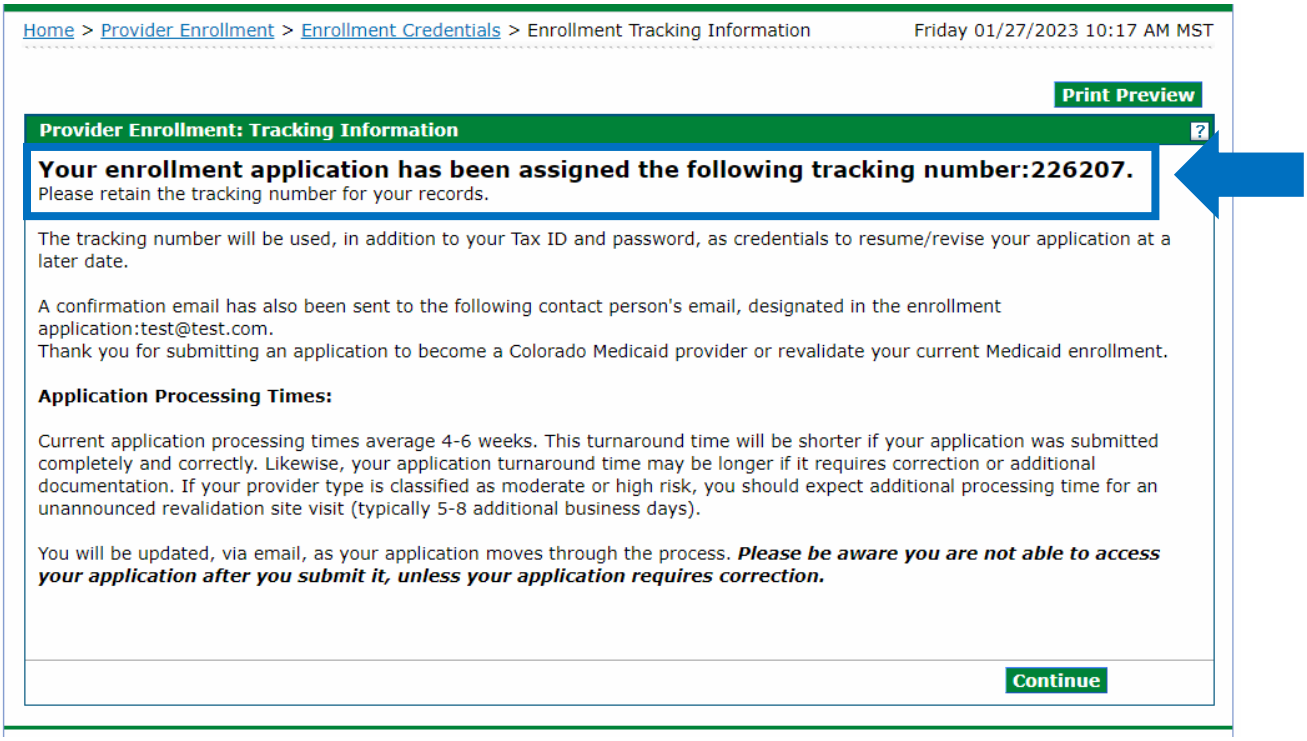
What is your father's middle name? - Enter father's middle name. This field is required for all providers saving their application. This user-defined response can have a maximum of 50 alphanumeric characters.

Tip: It is very important that the user store the password somewhere that they will not forget. The password cannot be reset for enrollment applications. If the password and security question answers are lost, the user will be unable to access the application and will need to begin a new enrollment application.

Select "**Submit**" to save this information and proceed to the next panel. Select "**Cancel**" to stop this process and return to the Enrollment process.

Once the user selects the "**Submit**" button, the user will be directed to the next panel that will assign the application tracking number. This panel will give the Application Tracking Number (ATN) that will be required to resume the application. In the upper right corner of this panel is a "**Print Preview**" button. Use this button to send a copy of this panel to a local or network printer connected to the computer.

Provider Enrollment: Tracking Information Panel



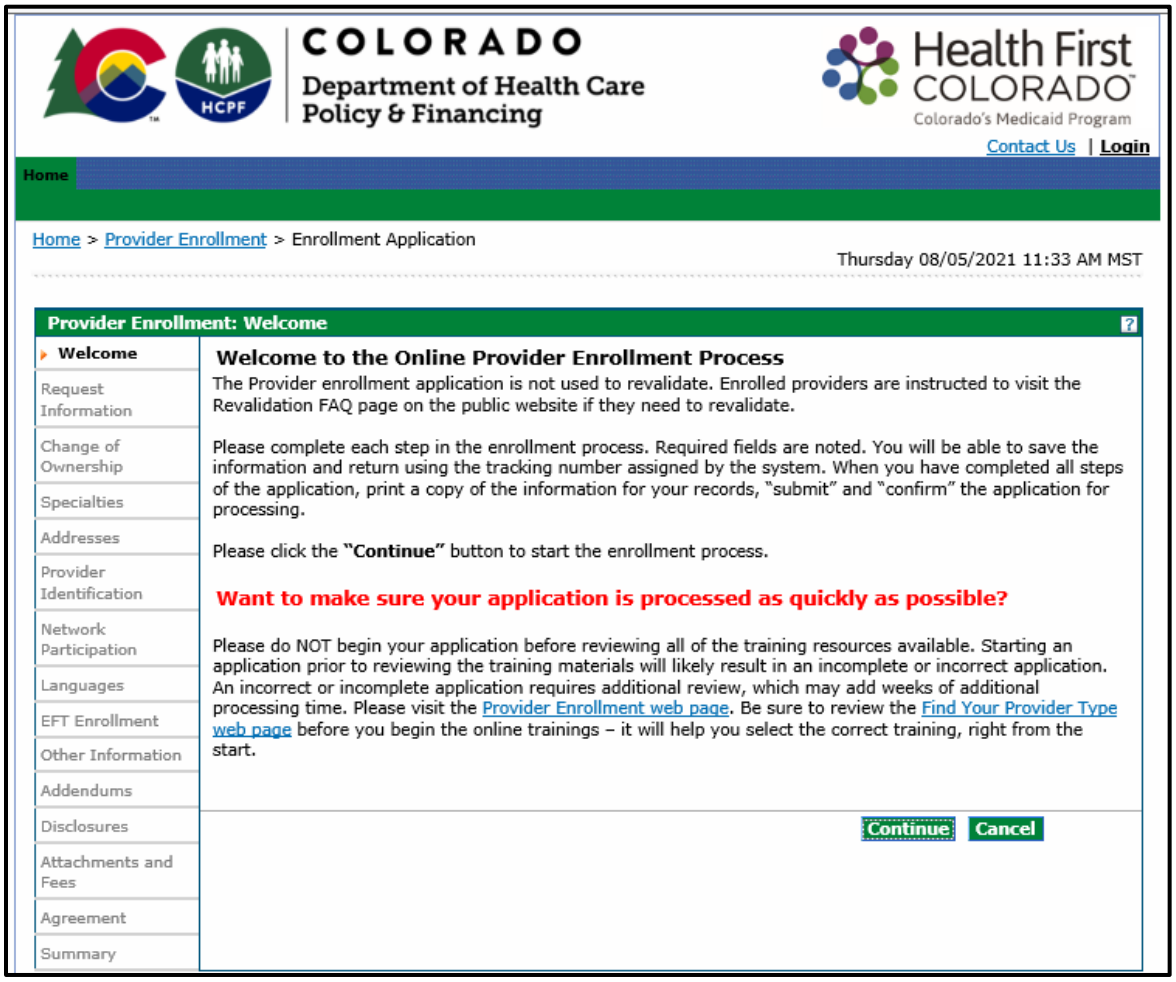
Select "**Continue**" to resume the enrollment process.

Note that on the upper left side of the panel, the bolded title indicates the panel that is currently open. Each panel becomes a clickable link as the panels are completed through the enrollment process, allowing a previous panel to be accessed if a change is needed.

Going back to a previous panel does not save the data entered. In order to save the data entered in an application click either the "**Continue**" or "**Finish Later**" buttons.

Welcome Panel

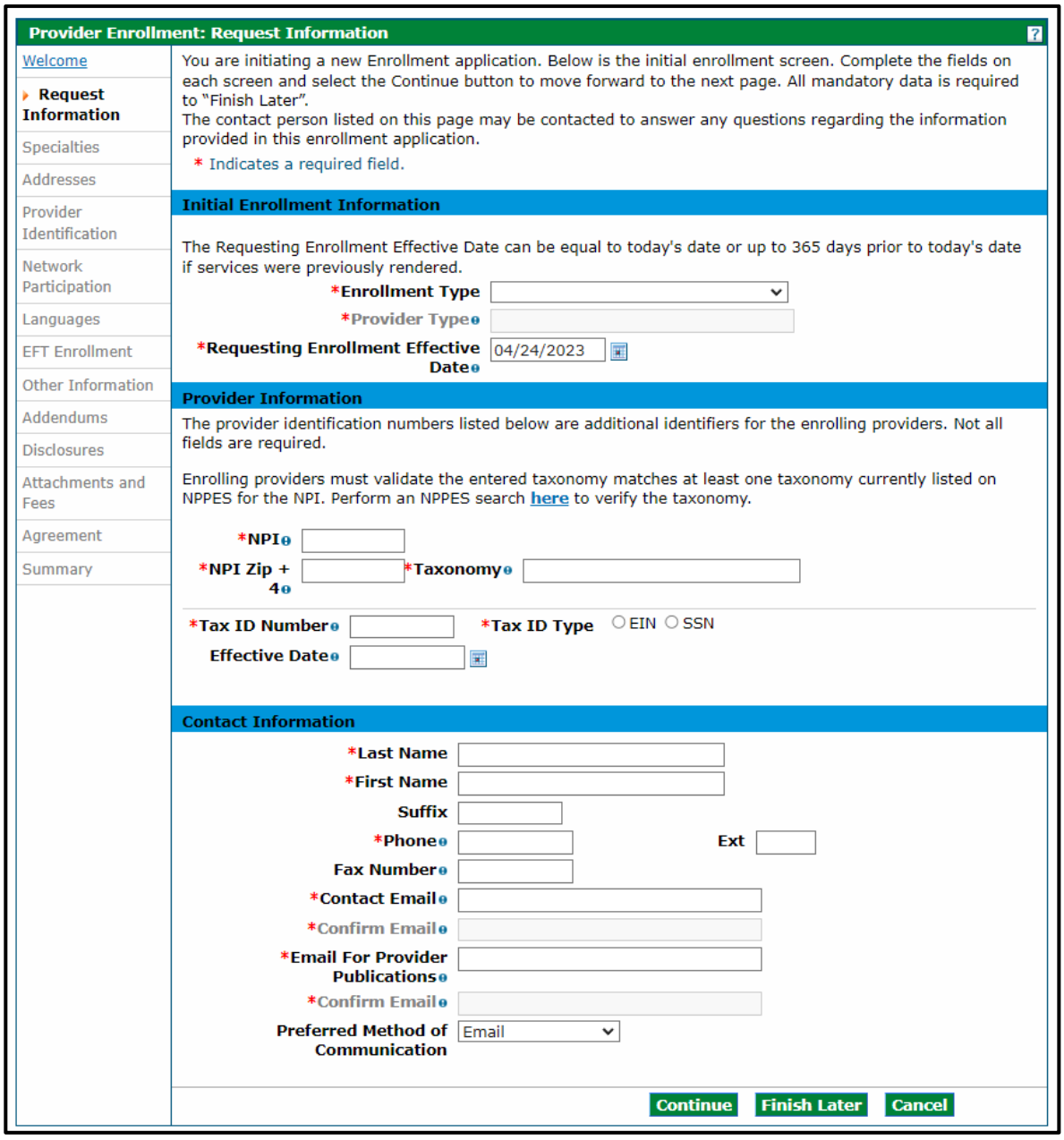
Once the user is ready to begin the enrollment process and has selected the **"Enrollment Application"** link, the first panel is the Welcome panel.



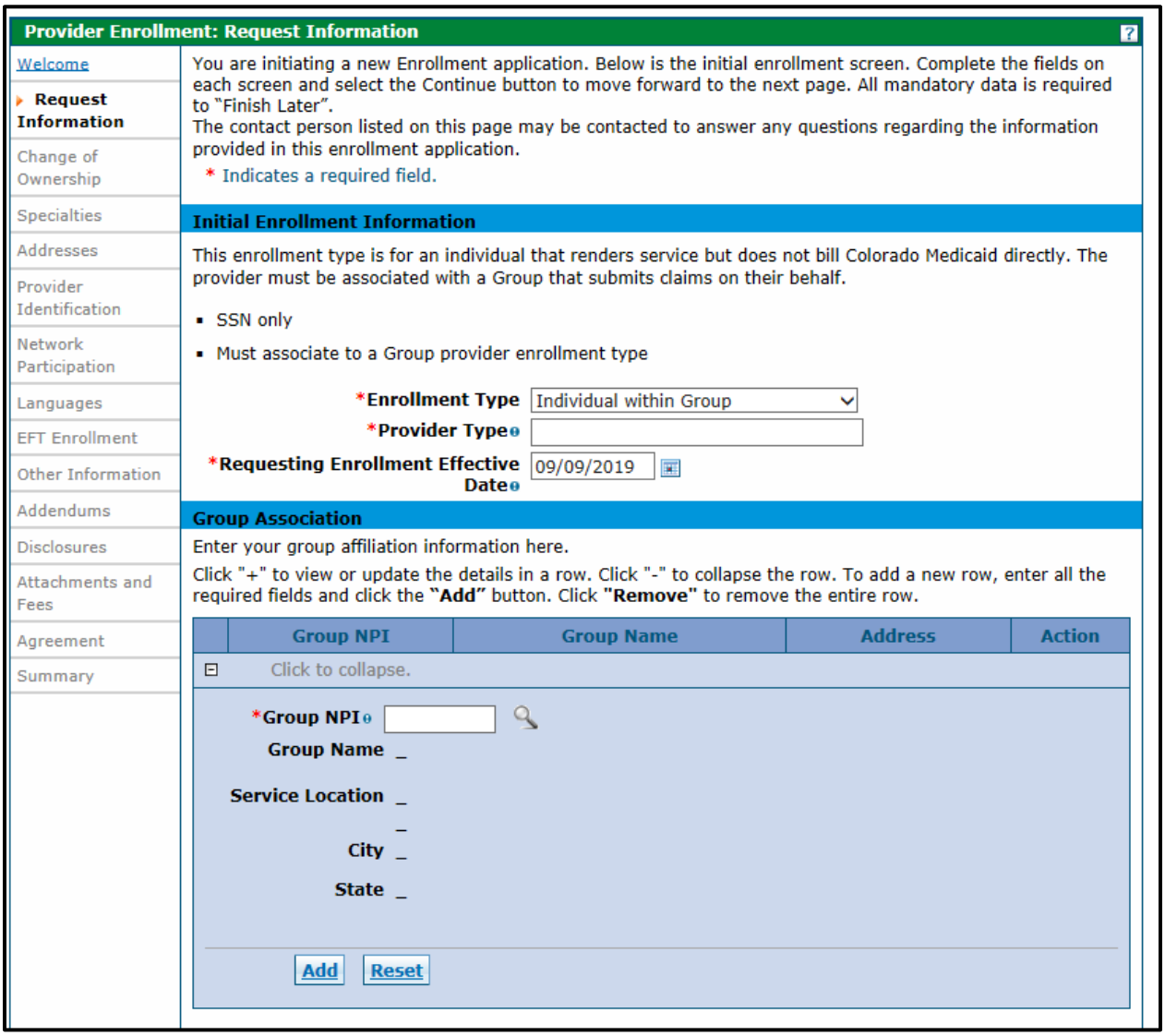
The Welcome Panel gives some brief instructions. Select the "**Continue**" button to go to the next panel of the application.

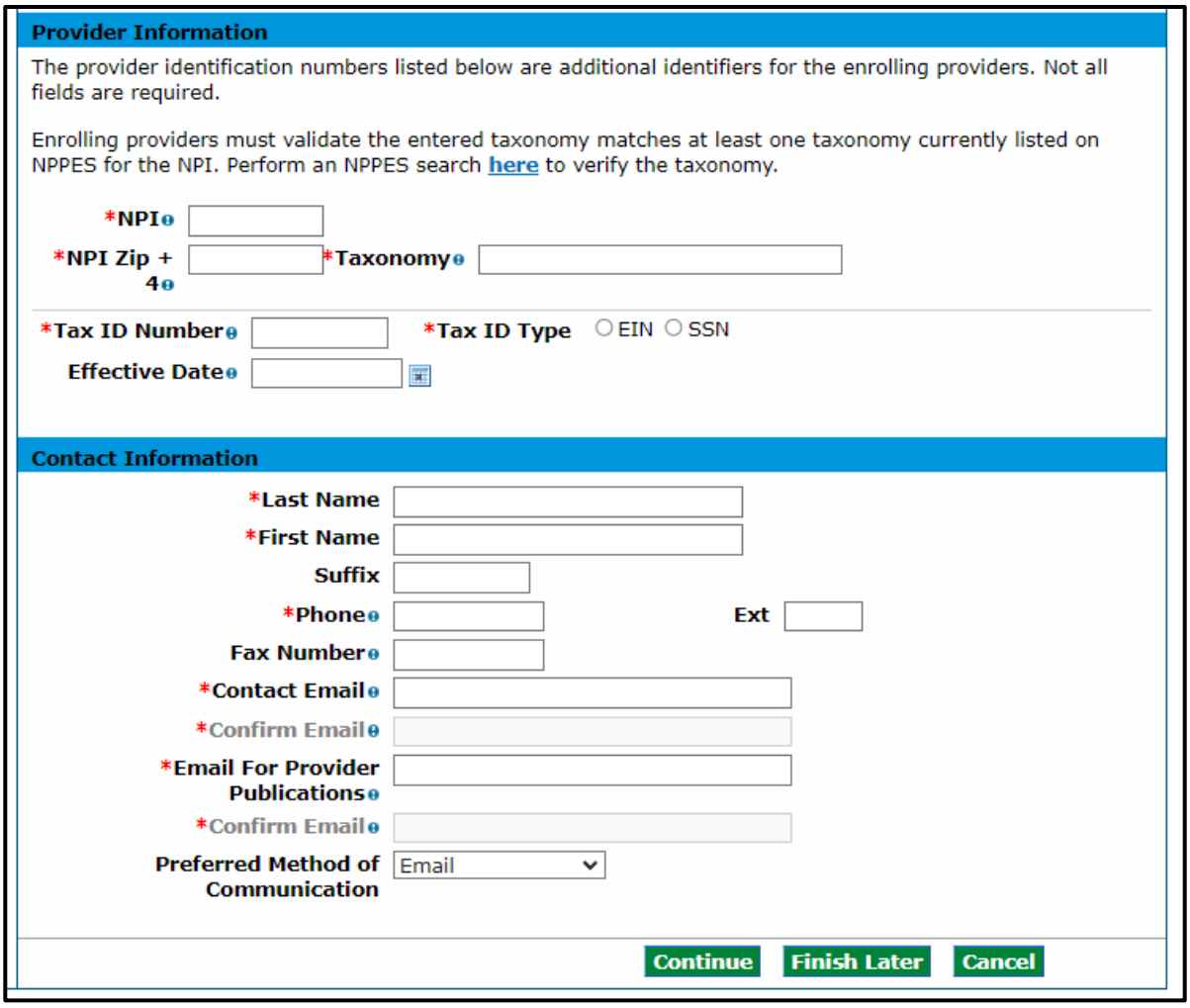
Request Information Panel

After clicking "**Continue**" from the Welcome Panel, the Request Information panel will be displayed.

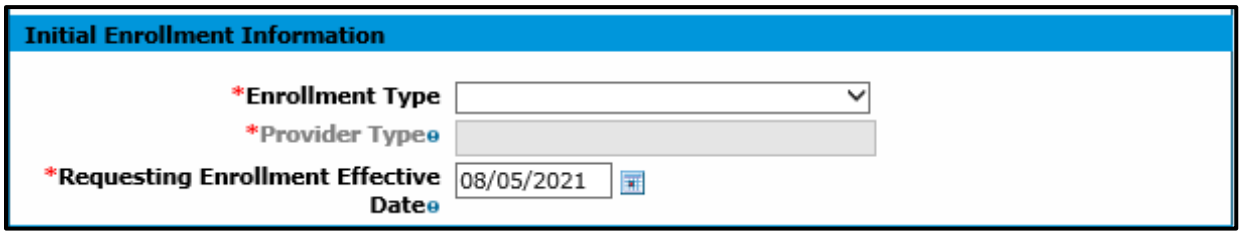


*The example below is for an Individual Within a Group enrollment type. The panel screen may appear similar to the following.





Initial Enrollment Information Section



Enrollment Type

On this panel, the user will select the Enrollment Type by clicking the drop-down next to Enrollment Type. Refer to the Provider Enrollment Manual Overview section above for explanation of enrollment types.

Provider Type

In the Provider Type field, enter two asterisks (**) to see all valid provider type choices, specific to the Enrollment Type that was selected in the prior field. If ** does not return the correct value that the user

is trying to enter, type the first few characters of the word. For example, type “Phys” and the panel will return items with “Phys” in the value, e.g., Physician and Physician Assistant.

The Information by Provider Type web page is a link to the list of all the available provider types supported in the Colorado interchange. These are the **ONLY** provider types the system will accept.

For the purposes of this example, we will choose Physician.

Requesting Enrollment Effective Date

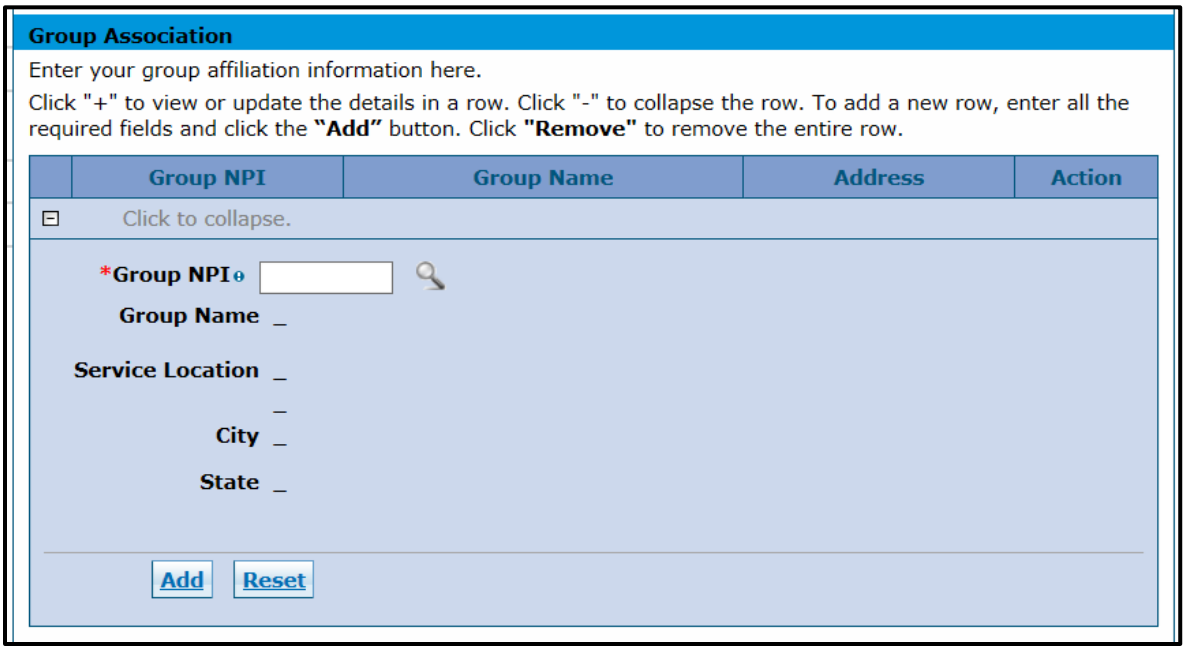
The "Requesting Enrollment Effective Date" field is defaulted to the current date for new enrollment applications. Users may enter a backdate up to 10 months prior to the current date in the "Requesting Enrollment Effective Date" field.

For providers resuming an enrollment application that is still in process, the "Requesting Enrollment Effective Date" field will be populated with the date entered when the application was last saved. That date must be within 10 months prior to the current date.

A backdate (up to 10 months in the past) can be requested; however, the request is not a guarantee of approval. Additionally, any required licenses, certifications, insurance, or specialties must be effective on the requested enrollment effective date.

Complete the remainder of the enrollment application. If the enrollment and backdate request are approved, the provider will receive a Welcome Letter which will contain the provider’s backdated contract effective date.

Group Association Section (Only for Individual Within a Group Enrollment Type)



This section of the Request Information Panel is the Group Association panel. This panel is required and will only display for providers that previously selected “Individual within a Group” as the Enrollment Type. All groups that the individual provider will affiliate to should be entered in this section.

Prior to completing this portion of the Enrollment process, please check with the Group representative(s) to make sure the groups are enrolled. If a Group is not enrolled, the affiliation cannot be completed.

Group NPI

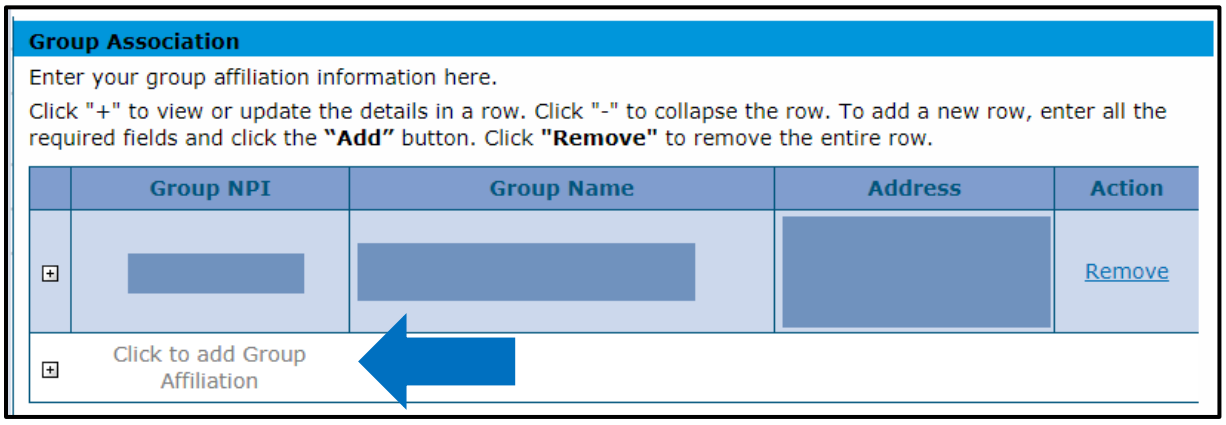
Enter the Group's NPI. If the NPI entered returns a single group location, the enrolled group's name, service location address, city & state will populate. Click the "**Add**" button to add this group affiliation.

If the group NPI entered is associated with multiple locations, an error message will display at the top of the panel indicating "Provider ID does not return a single Provider. Click the magnifying glass to search for a provider." Click the magnifying glass icon located next to the NPI field to display a list of address locations for the group NPI entered. Choose the appropriate address location from the list, then click the "Add" button to add the affiliation.

If the information is not correct and the user would like to start over, click the "**Reset**" button and re-enter the information.

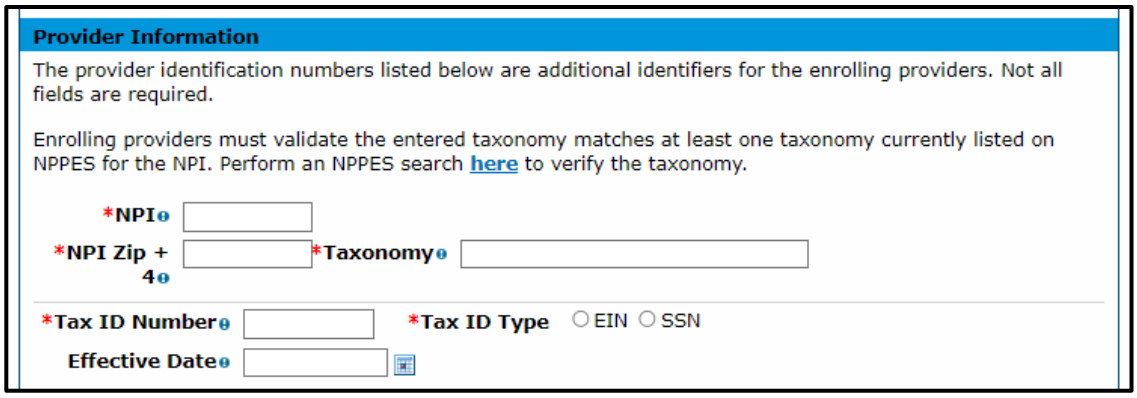
After the user clicks the "**Add**" button, the panel will update and will look similar to the following:

Group Association Section - Add



If an individual is part of more than one group, indicate all groups by adding each affiliation here. If an individual is affiliated to more than 16 groups, the 17th through last group will need to be a separate attachment uploaded in the "Attachment and Fees" panel.

Provider Information Section



Enter the requested information within this section for the provider who is enrolling on the application including NPI Number, Provider Taxonomy, and Tax ID.

Note: Not all provider types will have an NPI number. For the purposes of this example, the red asterisk indicating a required field is driven by the previous selection of "Physician".

NPI – Enter the applicant's 10-digit National Provider Identifier. This information is required for most provider types. Some Atypical providers may not need an NPI.

NPI Zip + 4 – Enter the zip code associated with the service address, as listed in the NPPES NPI Registry. Enter a 9-digit zip code. If an NPI is not required for the selected provider type, no entry is required in this field.

Taxonomy Codes – Enter the 10-digit alphanumeric Taxonomy code that classifies the enrolling provider as a healthcare provider according to the services provided. Entering two or more characters to begin a search populates a drop-down of applicable taxonomies where the user can then select an entry from the list that is shown. The entered taxonomy must match at least one taxonomy currently listed on NPPES for the NPI. After selecting a taxonomy, a popup must be acknowledged that the application will be returned or possibly denied if the taxonomy does not match before continuing the application.

If the selected provider type does not require an NPI, no entry is required in this field.

Tip: Refer to the 'Provider Taxonomy Codes' under the 'Additional Required Information' section of this manual for additional taxonomy code information.

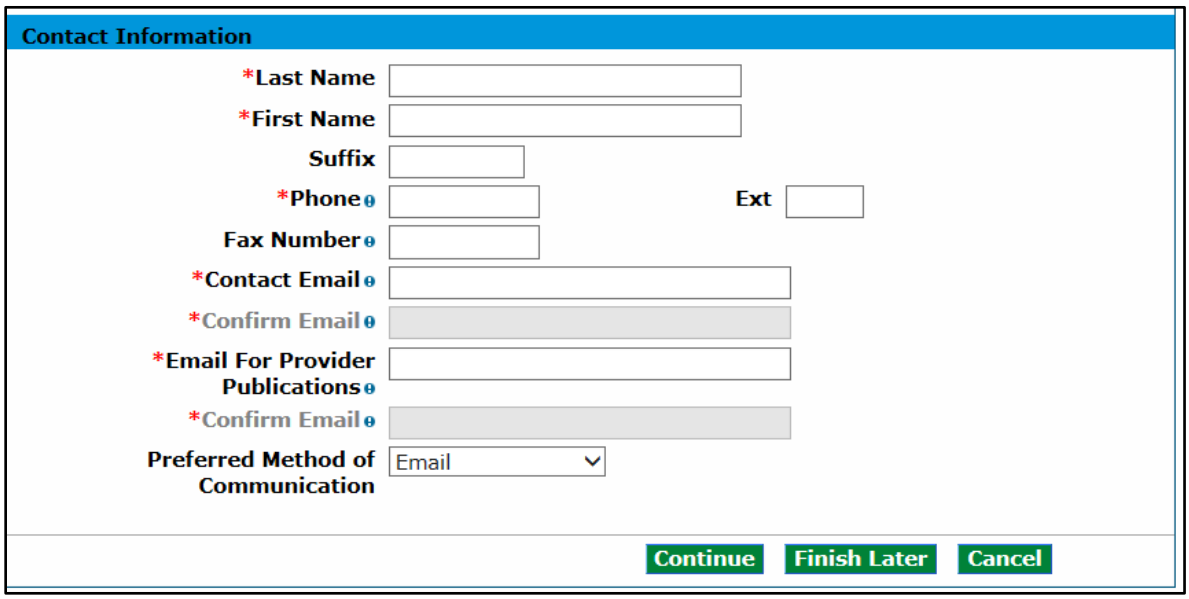
Tax ID Number – Enter the 9-digit EIN or SSN associated with the enrolling provider. This field is required for all providers.

Tax ID Type – Select whether an EIN or SSN was entered in the Tax ID Number field. This field is required for all providers. Group, Facility, and some Atypical providers will require an EIN. Individual providers will require an SSN.

Effective Date

- If an EIN was entered - The effective date for this field should be the date the corporation (entity) began doing business.
- If an SSN was entered - The effective date for this field should be the practitioner's date of birth.

Contact Information Section



Indicate required contact information for the practice or organization on this panel.

Last Name – Enter the last name of the individual who will receive correspondence regarding this enrollment. This field allows up to 50 alphanumeric characters. This field is required for all providers.

First Name – Enter the first name of the individual who will receive correspondence regarding this enrollment. This field allows up to 25 alphanumeric characters. This field is required for all providers.

Suffix – If appropriate, enter the suffix for the name of the individual who will receive correspondence regarding this enrollment. This field allows up to ten alphanumeric characters. This field is not required.

Phone – Enter the office phone number of the individual who will receive correspondence regarding this enrollment. This field allows a 10-digit phone number, including area code using 999-999-9999 format. This field is required for all providers.

Ext – If appropriate, enter the phone extension of the individual who will receive correspondence regarding this enrollment. This field is not required.

Fax Number – Enter the fax of the individual who will receive correspondence regarding this enrollment. This field allows a 10-digit phone number, including area code using 999-999-9999 format. This field is not required.

Contact Email – Enter the valid Email address of the individual who will receive correspondence regarding this enrollment. Enter email with 'name@domain' format. This field is required for all providers.

Confirm Email – Confirm the valid Email address of the individual who will receive correspondence regarding this enrollment. Enter email with 'name@domain' format. This field is required for all providers.

Email for Provider Publications – Enter the valid Email address of the contact individual at the practice or organization to which Provider Publications should be sent. Enter email with 'name@domain' format. This field is required for all providers.

Confirm Email – Confirm the valid Email address of the contact individual at the practice or organization to which Provider Publications should be sent. Enter email with 'name@domain' format. This field is required for all providers.

Preferred Method of Communication – Selecting "Email" will ensure more timely receipt of correspondence.

Change of Ownership Panel

After clicking "**Continue**" from the Request Information panel, entering Credential information, and generating an ATN, the Change of Ownership panel displays for Facility, Group or Atypical enrollment types.

Note: The Change of Ownership panel will not display for Individual within Group, Billing Individual, Ordering, Prescribing, Referring (OPR) or PACE-Only Subcontractor provider enrollment types.

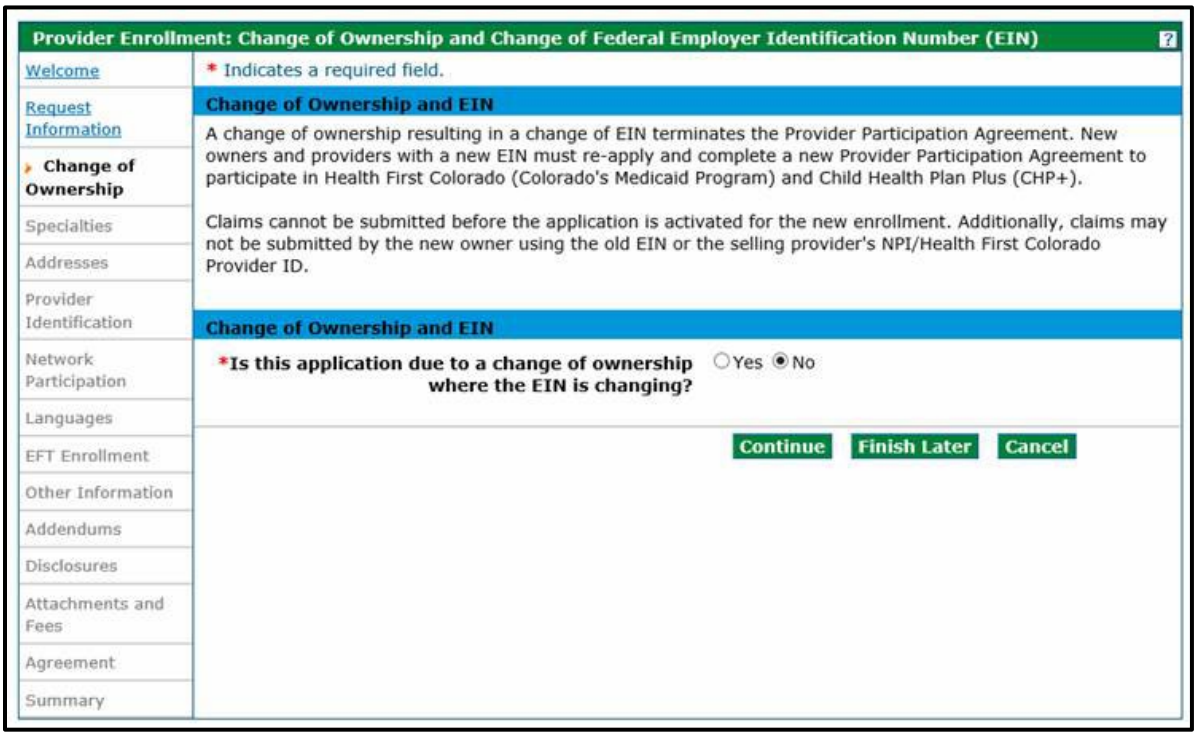
The panel initially displays with the field "Is the application due to a change of ownership where the EIN is changing?" set to "**No**".

Change of Ownership and EIN Section

Indicate if this enrollment is due to a change of ownership or Federal Employer Identification Number (EIN).

For a "**No**" answer, click "**Continue"** to proceed to the next panel of the application.

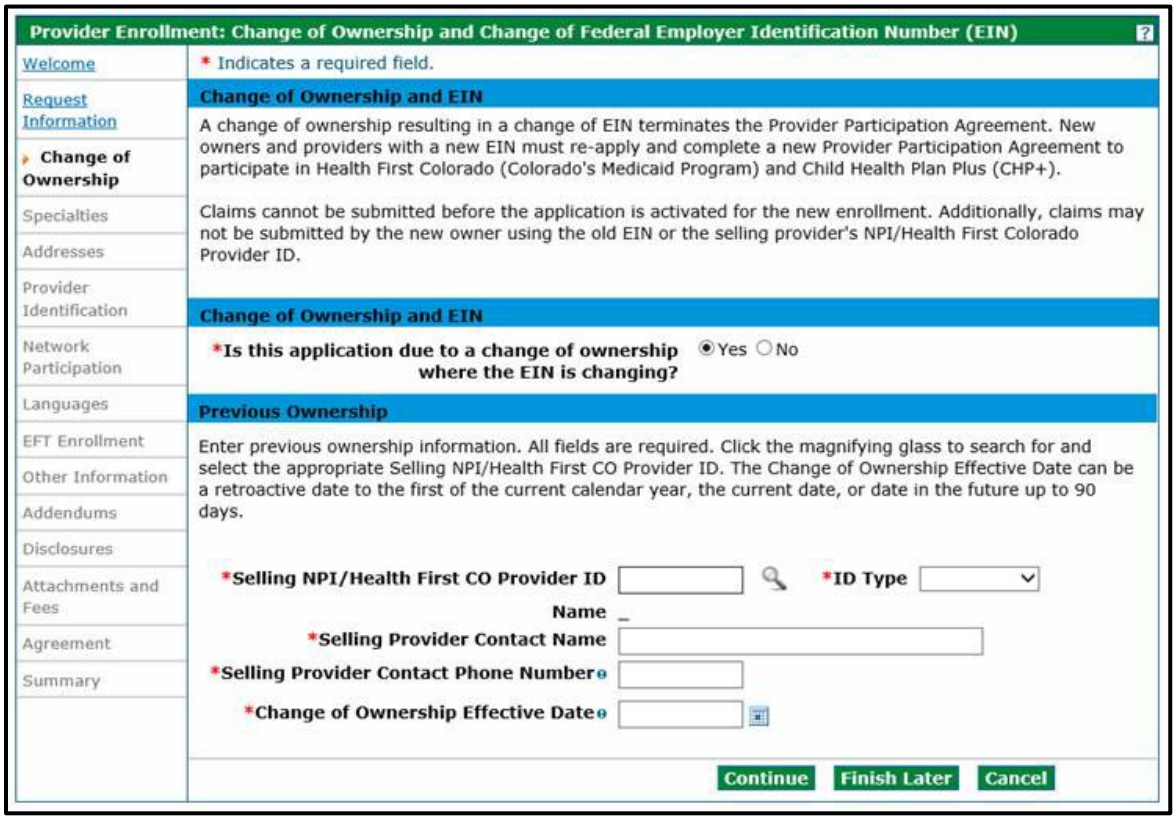
A "**Yes**" answer displays the Previous Ownership section.



Note: Providers are reminded that new owners and providers with a new EIN must re-apply submitting a new enrollment application that includes the Selling Provider's information and a new Provider Participation Agreement. Changes in ownership that do not result in an EIN change may continue to be submitted through the Disclosures panel of the Provider Maintenance or Revalidation applications. A change of ownership or change in EIN is not applicable to an individual (SSN) enrollment. For additional information on Change of Ownership (CHOW), visit the Provider FAQ Central and select the Change of Ownership (CHOW) FAQs heading.

Previous Ownership Section

Complete all the required fields under the Previous Ownership section with the selling provider's information.



Selling NPI/Health First CO Provider ID – Enter the Medicaid number or NPI number of the selling provider or previous provider. Click the magnifying glass to search for a provider.

ID Type – Use the drop-down to select the ID Type.

Name – This field will populate with the NPI/Provider ID being entered.

Selling Provider Contact Name – Enter the contact for the selling provider's first and last name.

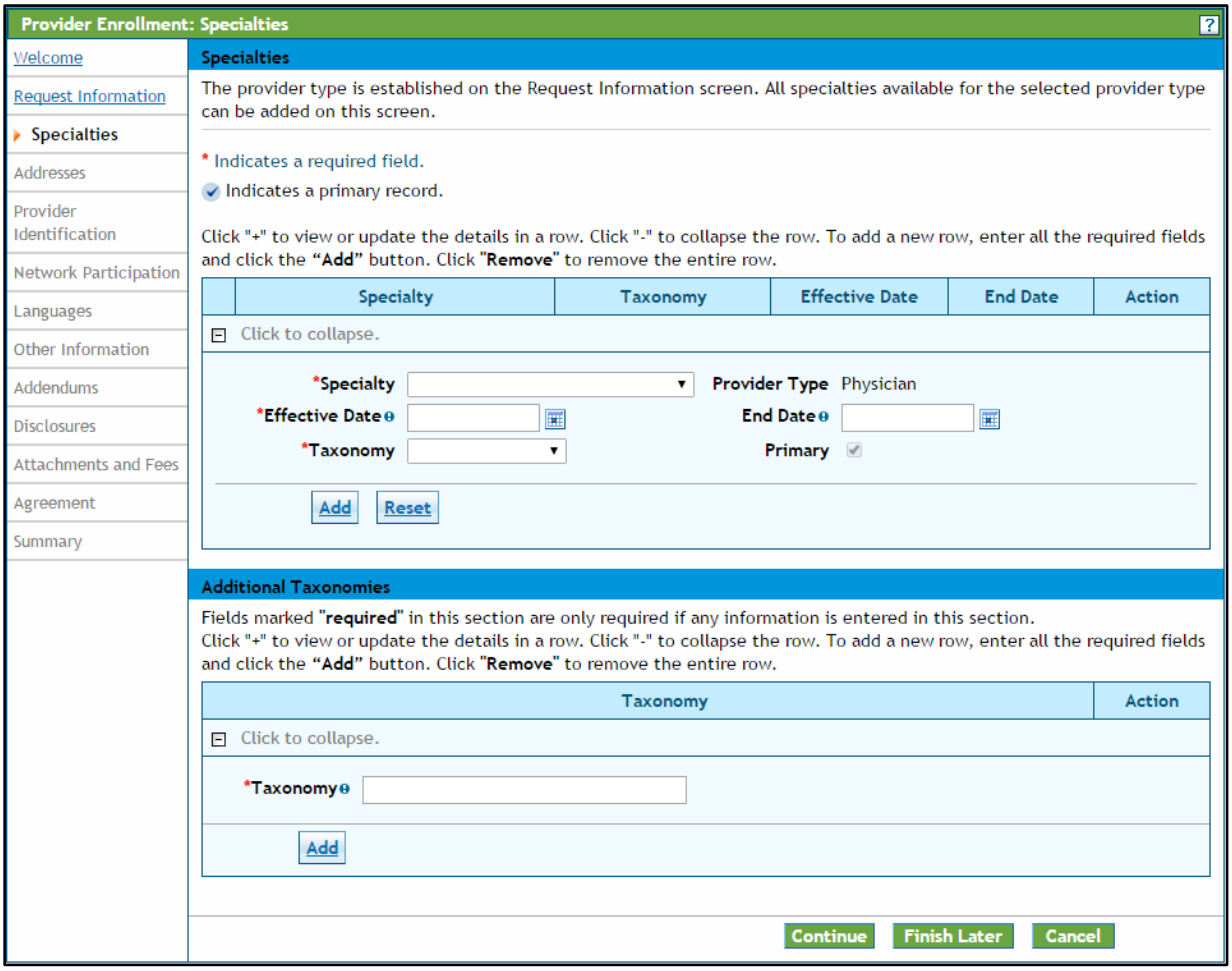
Selling Provider Contact Phone Number – Enter the selling provider's phone number. This field allows a 10-digit phone number, including area code using 999-999-9999 format. This field is required.

Change of Ownership Effective Date – Enter the effective date of the change of ownership.

When all fields are entered, select "**Continue**", "**Finish Later**" or "**Cancel**".

Note: Upon receipt of a completed Change of Ownership enrollment application, the selling provider will receive a notification from Health First Colorado with instruction on submitting a voluntary disenrollment application. The change of ownership enrollment application cannot be processed for approval until the selling provider completes and submits a voluntary disenrollment application through the Provider Web Portal.

Specialties Panel

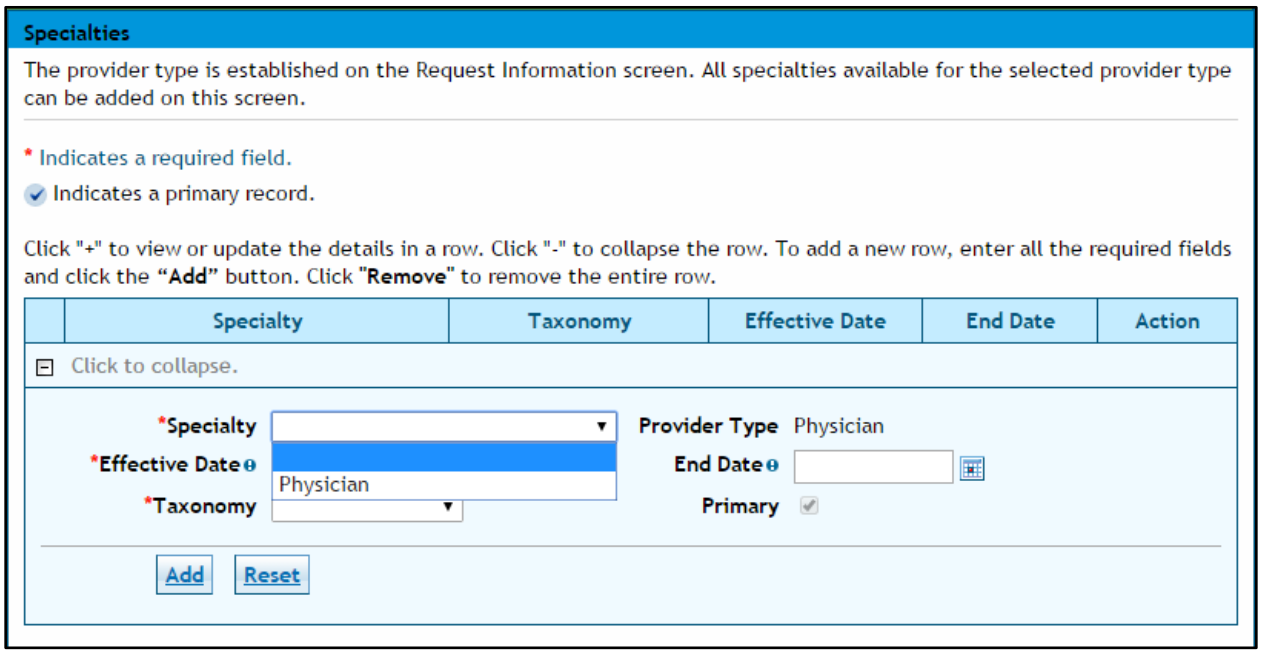


The specialties that will be available on this panel are based on the Enrollment Type and Provider Type selection made on the Request Information screen. At least one specialty is required. Some provider types only allow for one specialty, and some provider types allow for multiple specialties. However, only one specialty can be designated as the primary specialty. The system will only accept certain specialties.

Refer to the Provider Type, Enrollment Type and Enrollment Requirements section of this document for additional information on provider types, enrollment types and specialties.

A Taxonomy code must be provided for each specialty, except for when "**Atypical**" is selected as the Enrollment Type.

Specialties Section



Specialty – Use the drop-down box to select "**Specialty**". The specialty entered here will drive the choices available under the "**Taxonomy**" drop-down.

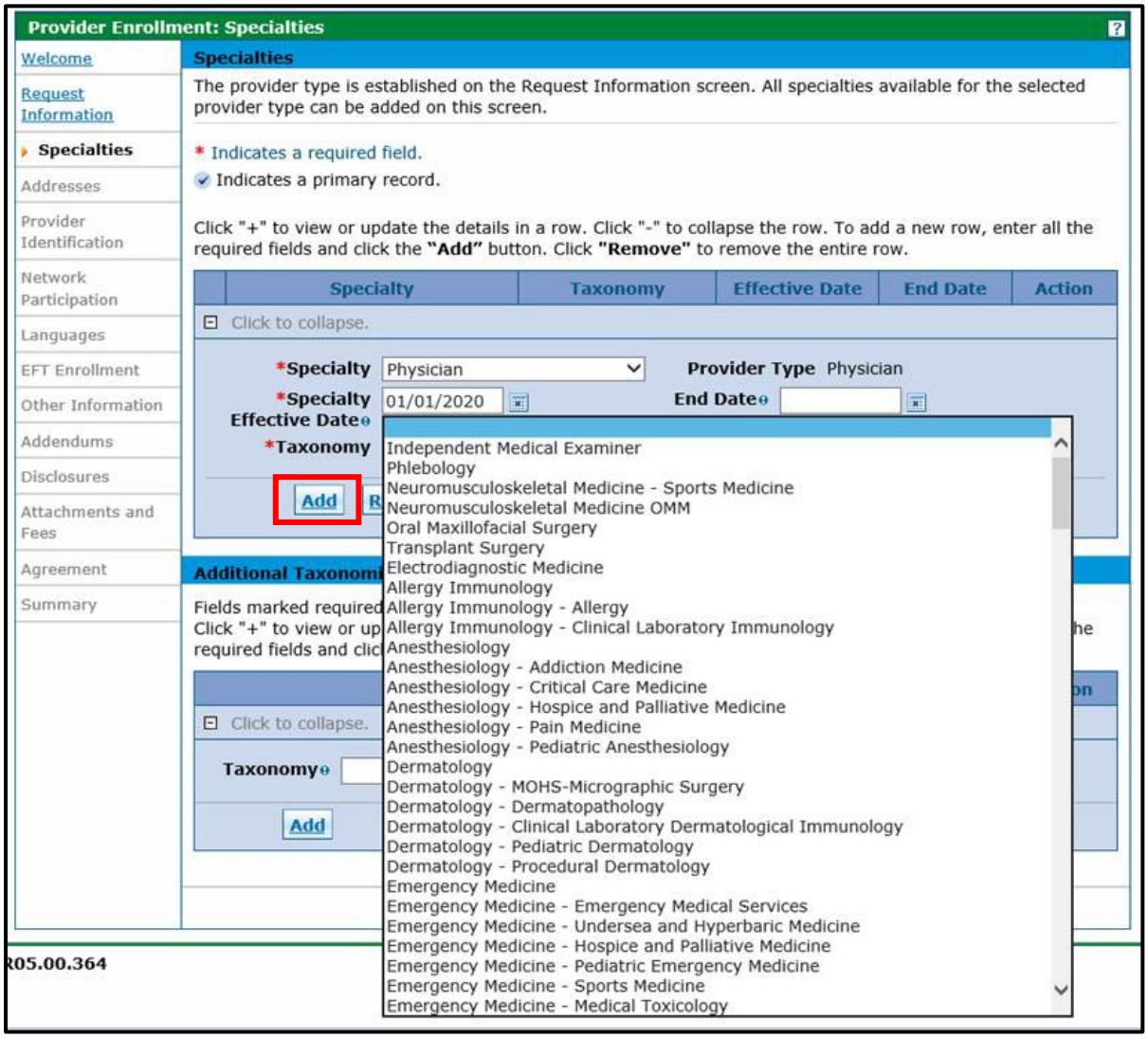
Note: There are many instances where the only "Specialty" option is the "Provider Type" chosen. If this is the case, select the only option available and then use the "Taxonomy" drop-down to indicate the area of specialty.

Example: If the enrolling provider is a Pediatrician, select the only option shown (Physician) as the specialty, and then choose Pediatrics in the "Taxonomy" drop-down.

Effective Date – Enter the effective date of the specialty. This selection can be done by clicking the calendar icon next to the date field. The calendar icon is shown here. This is a required field.

End Date – Enter the End date, if appropriate, for the specialty. This selection can be done by clicking the calendar icon next to the date field. The calendar icon is shown here. This is not a required field.

Specialties Section – Taxonomy Code



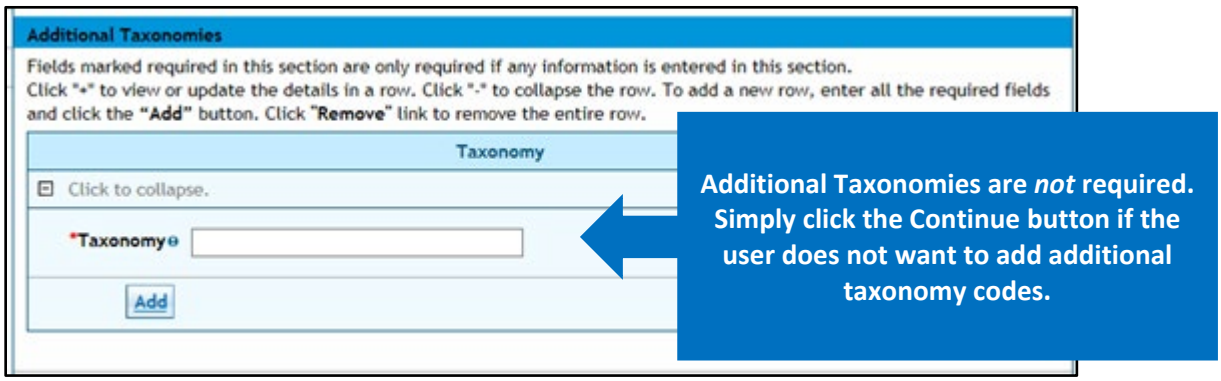
Taxonomy – Select a taxonomy (specialization) that is associated with the provider. This selection is accessed via the drop-down. This is a required field.

Primary – Only one specialty can be designated as the primary specialty.

At least one taxonomy entered must match to one taxonomy listed in the National Provider Identifier NPI registry.

Do not forget to click the Add button!

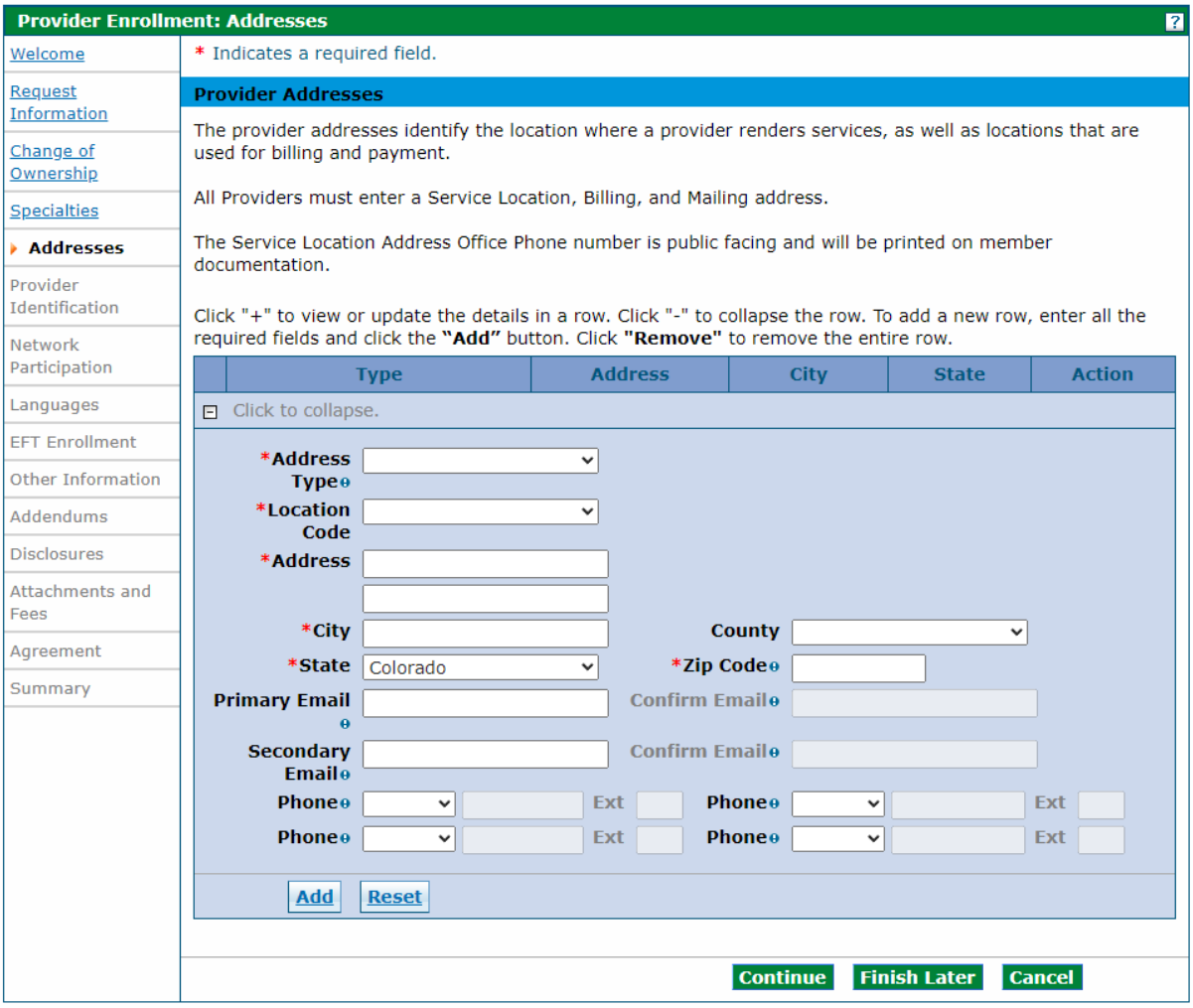
Additional Taxonomies Section



Taxonomy – Select an additional taxonomy code **if desired**. This is an alphanumeric look-up search field that responds to the characters entered into the field to return a list of valid taxonomy codes. Enter 2 or more characters to begin a search then select an entry from the list that is shown.

This panel is complete, select "**Continue**", "**Finish Later**", or "**Cancel**".

Addresses Panel



All providers regardless of enrollment type are required to enter three different address types: Service Location, Mailing and Billing.

There are slight differences in the information collected for each address type.

Refer to the Provider Type, Enrollment Type and Enrollment Requirements section of this document for additional information on these address types.

Note: Business entities (enrolling with a federal employer identification number) must complete a separate enrollment application for each service location address.

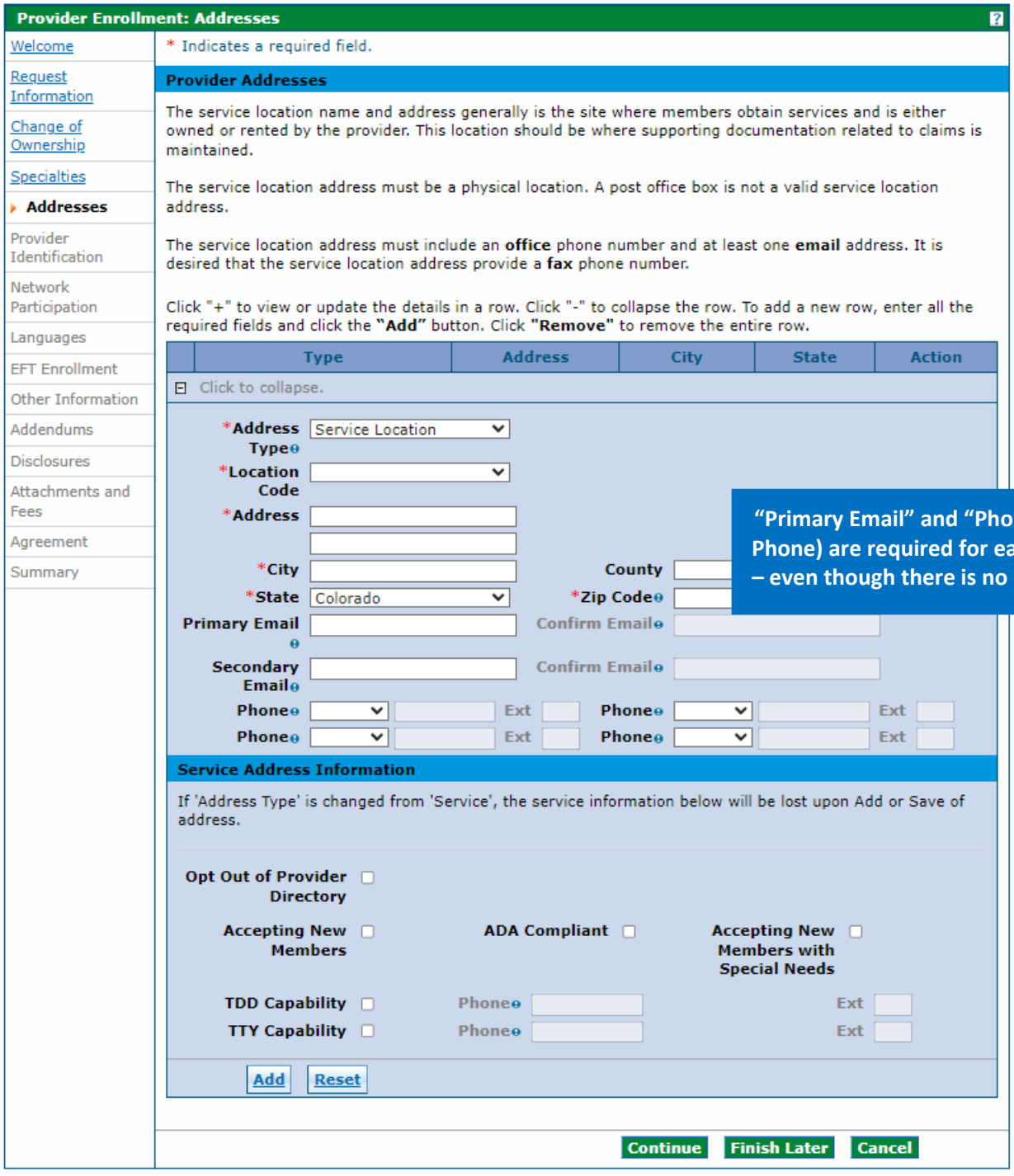
Individuals (enrolling with a Social Security Number) are limited to one enrollment only.

Provider Addresses Section

To begin, select the address type from the Address Type drop-down. Complete the fields displayed. A description of each field is provided below.

When the address type "Service Location" is selected, an additional section will display in the panel. Refer to the example below.

Adding Service Location Address Information



Address Type – Use the drop-down to select the "Service Location". This will immediately open the "Service Address Information" panel at the bottom of the screen. This is a required field.

Location Code – Use this drop-down to indicate the address location in relation to the State of Colorado. Possible selections are Border Provider, In-State, and Out-of-State. This is a required field.

Note: To see a list of approved Border Providers click the "?" Help button on the upper right corner on this panel.

- **Users may also visit the Billing Manuals web page and reference Appendix F under the Appendices drop-down for a list of approved border cities/town by bordering state.**
- **Visit the Information by Provider Type web page, select the appropriate provider type drop-down and refer to the "BT Allowed?" field in the table (refer to the example below) to determine if your provider type allows enrollment when the service location is in an approved border town.**

Risk Level:	Limited	Fee Req'd?	No	NPI Req'd?	No
Medicare Req'd?	No	OOS Allowed?	Yes	BT Allowed?	Yes

Address – Enter the street address of the location. (The Service Location must be a physical address and cannot be a PO Box.) This address can be two lines, if needed. Suite numbers, building or unit numbers should be submitted on the 2nd line. This field allows up to 55 alphanumeric characters. This is a required field.

City – Enter the appropriate city or town for this location. This field allows up to 30 alphanumeric characters. This is a required field.

County – Enter the appropriate county for this location. This field allows up to 30 alphanumeric characters. This is not a required field. Do not select "State of Colorado" as the County.

State – A drop-down of the valid state options that a provider may select for an address. This defaults to Colorado. This is a required field.

Zip Code – Enter the 9-digit zip code for this location. This is a required field.

Primary Email – Enter the primary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is a required field.

Confirm Primary Email Address – Re-enter the primary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is a required field.

Secondary Email – Enter the secondary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is not a required field.

Confirm Secondary Email Address – Re-enter the secondary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is not a required field unless the Secondary Email Address field is completed.

Phone (Type 1 of 4) – Use the drop-down and select the **Office** phone number type. **At least one "Office" number is required per location.**

Phone (1 of 4) – Enter the 10-digit office phone number associated to the location. This is a required field. The Service Location Address Office Phone number is public facing and will be printed on member documentation.

Ext (1 to 4) – When applicable, enter the extension for the office phone number associated to the location. This is not a required field.

Phone (Type 2 through 4) – For additional phone numbers, use the drop-down to select the type of phone number being entered. Available selections are Cell, Fax, Office, Toll Free, and Other. These are not required fields.

Phone (2 through 4) – When applicable, enter additional 10-digit phone numbers associated to the location and phone type indicated. These are not required fields.

Ext (2 through 4) – Enter extensions applicable to the additional phone numbers entered. These are not required fields.

Service Address Information

These fields only display on the Service Location address panel.

Opt Out of Provider Directory – Use this check box to indicate whether the Service Location should be omitted from the provider directory. Leaving this field blank will include the location in the provider directory. This field is not required.

Accepting New Members – Use this check box to indicate if the Service Location is accepting new patients. This field is not required, however leaving the field blank will indicate that the location is not accepting new patients.

ADA Compliant – Use this check box to indicate if the Service Location is compliant with the American Disabilities Act (ADA). This field is not required; however, leaving the field blank will indicate that the location is not compliant.

Accepting New Members with Special Needs – Use this check box to indicate if the Service Location is accepting new patients with special needs. This field is not required; however, leaving the field blank will indicate that the location is not accepting new patients with special needs.

TDD Capability – Use this check box to indicate if the service location provides a telephone device for the deaf (TDD). This field is not required; however, leaving the field blank will indicate that the location does not offer TDD capability.

Phone (TDD) – Use this field to enter the 10-digit phone number associated with the TDD capability. This field is only required if the TDD Capability box is checked.

Ext (TDD) – Use this field to enter the 4-digit extension associated with the TDD if applicable. This field is not required.

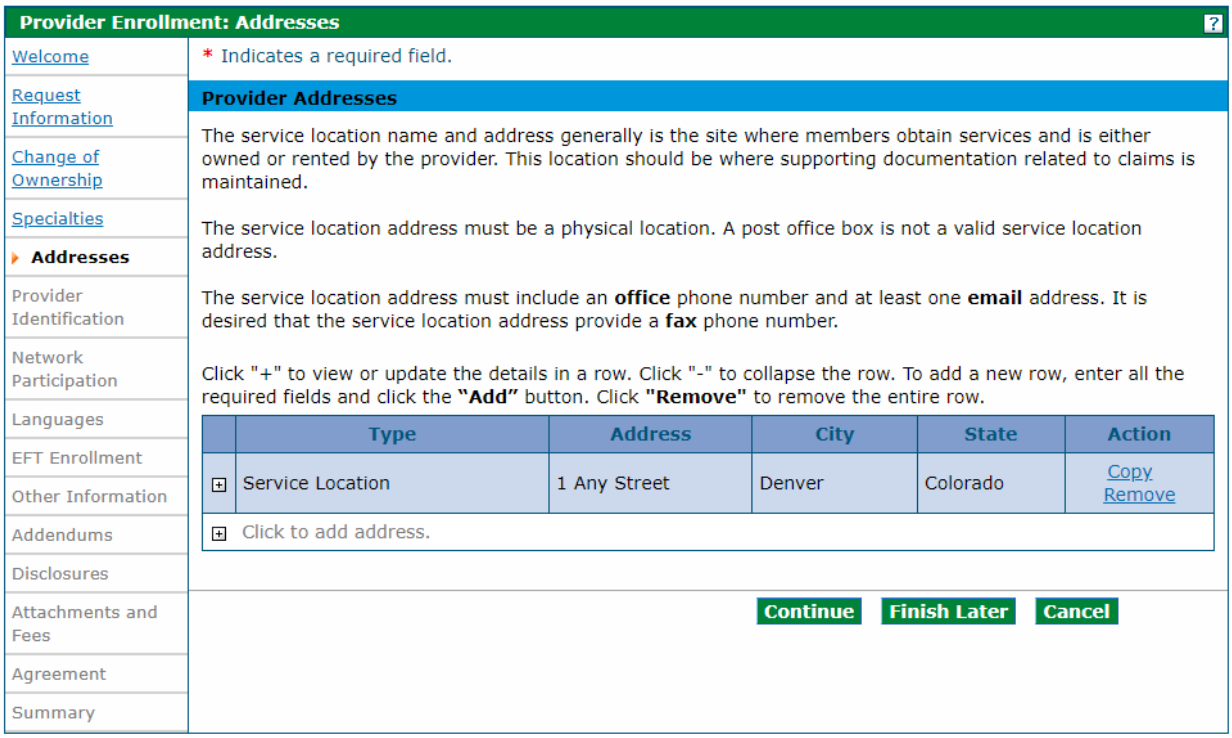
TTY Capability – Use this check box to indicate if the service location provides a telephone typewriter for the deaf (TTY). This field is not required; however, leaving the field blank will indicate that the location does not offer TTY capability.

Phone (TTY) – Use this field to enter the 10-digit phone number associated with the TTY capability. This field is only required if the TTY Capability box is checked.

Ext (TTY) – Use this field to enter the 4-digit extension associated with the TTY if applicable. This field is not required.

After entering the appropriate information on this panel, click the "**Add**" button. This will store the information in the application. This does not save the information until either the "**Finish Later**" button is clicked, or the application is submitted at the end of the process. After the "**Add**" button is clicked, the panel will update to the version below.

Provider Addresses Section – Service Location Added

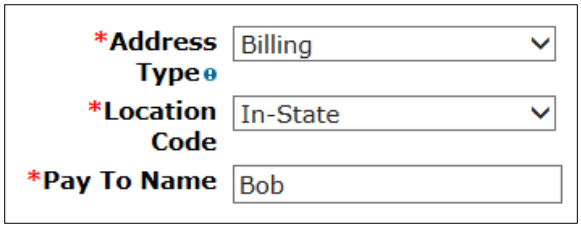


Click the "**+**" symbol located beside the words "**Click to add address**" to begin the process to add the next address. Click "**Copy**" if the next address is the same, then edit as needed. The "**Copy**" feature is helpful when two or more addresses are the same.

Provider Addresses Section - Add another Address

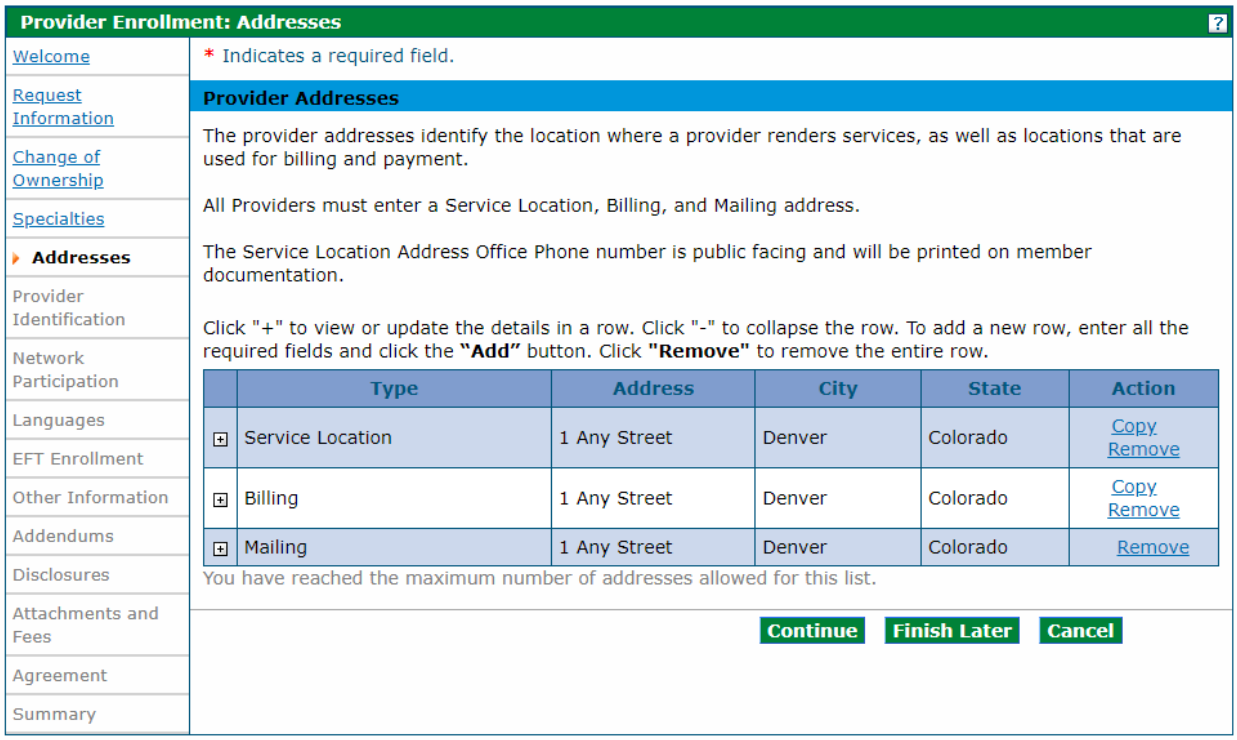
To add a Billing address or Mailing address select "**Billing**" or "**Mailing**" in the Address Type field and complete the remaining information. There is one additional field when the Billing or Mailing address panels are displayed.

Pay To Name or Mail To Name – Enter the person, area or entity to identify where billing or mailed information should be sent (e.g., Office Manager, Billing Manager, Front Desk, Mail Room, etc.) These are required fields.



To delete an entire row, click the "**Remove**" button located in the "**Action**" field. This will delete the entire row. Once deleted the row must be re-entered.

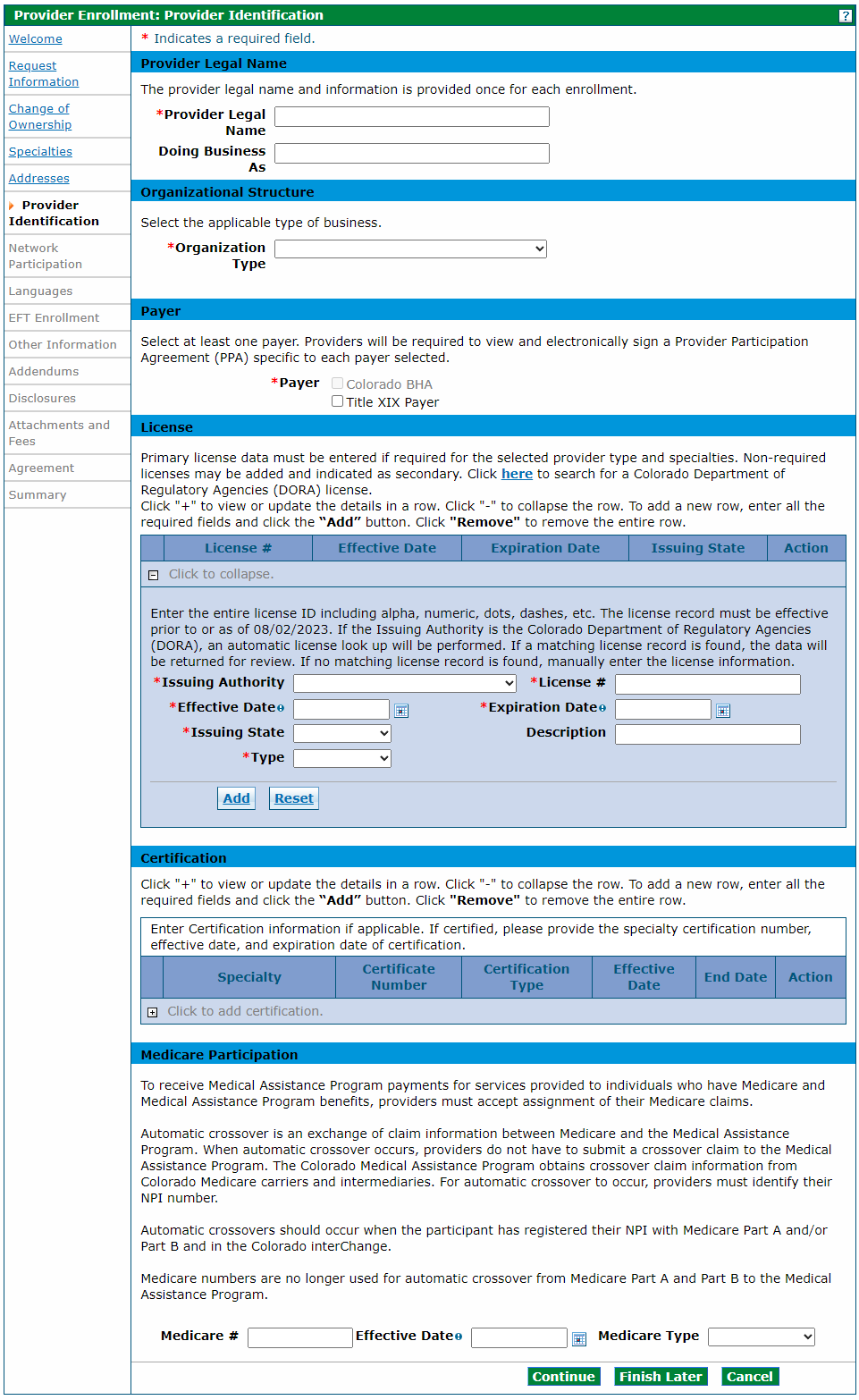
Provider Addresses Panel – Completed



When all three addresses are entered, select "**Continue**", "**Finish Later**", or "**Cancel**".

Provider Identification Panel

The example below displays a Group enrollment type. The panel may look similar to the following. Refer to the additional examples below.



The Provider Identification panel requests information such as the legal name, a group practice or facility information, school information, and any appropriate identification numbers, such as U.S. Drug Enforcement Administration (DEA), state license numbers, and Medicare numbers. Note that the Provider Enrollment Tool will present the user with the identification fields that are appropriate to the provider type, based on the previous selections. For example, an individual will be presented with fields to identify their education; however, a Facility application will not include these fields.

Below is a comprehensive list of all the Provider Identification fields that could be present:

Provider Legal Name Section

Group, Atypical or Facility Providers

Provider Legal Name – Enter the Provider Legal Name for a group, atypical provider, or facility. This field allows up to 70 alphanumeric characters. This is a required field.

Doing Business As – Enter the Doing Business As name of the provider, if applicable. This field allows up to 30 alphanumeric characters. This is not a required field.

Individual Providers

Last Name – Enter the last name for an individual provider. This field allows up to 60 Alphanumeric characters. This is a required field.

First Name – Enter the first name field for an individual provider. This field allows up to 25 alphanumeric characters. This is a required field.

Middle – Enter the Middle Initial associated to the middle name of the Provider. This field allows one letter.

Suffix – Enter the Suffix field for an individual provider, if applicable. This field allows up to ten alphanumeric characters. This field should be used to indicate MD, PhD, etc.

Organizational Structure Section or Individual Provider Section

Organizational Structure Section

Organization Type – Select the Organization type for the enrolling entity from the drop-down. Typical values could include Corporation, Estate, Trust, etc. If the user is unsure of the organization type the user may be able to find this information by performing a records search on the Secretary of State website.

Individual Providers Section

Gender – Select the gender associated with an individual provider from the drop-down. This is a required field.

Birth Date – Enter the birth date associated with the individual provider. This field allows eight numeric characters. This field is only displayed if the enrollment type is 'Individual within a Group', 'Ordering, Prescribing, Referring' (OPR) or 'Billing Individual'. The Birth Date must be between 0 and 150 years old. This must be entered as a valid value in the format 'MM/DD/YYYY'.

Degree – Select the appropriate professional degree received by the individual provider from the drop-down. Degree is a required field if any one of the "Professional Education fields" is entered.

School – Enter the Name of school from which the degree was received by the individual provider. This field allows up to 25 alphanumeric characters. School Name is a required field if any one of the Professional Education fields is entered.

Year of Graduation – Enter the year in which the provider obtained the degree. This field allows up to four numeric characters. Year of Graduation is a required field if any one of the Professional Education fields is entered. Year of Graduation cannot be more than 125 years in the past. Year of Graduation cannot be in the future.

Payer Section

Payer – Select the appropriate Payer. Applicable Payer checkboxes will be enabled and at least one Payer must be selected.

License Section

If the license is a Colorado Department of Regulatory Agencies (DORA), an automatic lookup will be performed when the Issuing Authority and License # are entered. If a match is found in DORA, the Effective Date, Expiration Date, and Issuing State will be retrieved and populated automatically.

Issuing Authority – Select the agency that issued the license. [Examples: Colorado Department of Regulatory Agencies (DORA), Colorado Department of Public Health & Environment (CDPHE)]. Issuing Authority is a required field if any one of the other License fields is entered.

License # – Enter the entire License Number including alphanumeric, dots, dashes, etc. This field allows up to 20 characters. License Number is a required field if any one of the other License fields is entered. Each license that is listed in the application must have a corresponding attachment for verification, showing the license number, the effective date and the expiration date of the license.

Effective Date (License) – Enter the effective date for the license number assigned to the provider. Be sure to enter the effective date and not the issue date. This field allows eight numeric characters. The Effective Date is a required field if one of the other License fields is entered. This must be entered as a valid value in the format 'MM/DD/YYYY'.

Expiration Date (License) – Enter the expiration date for the license number assigned to the provider. This field allows eight numeric characters. The Expiration Date is a required field if one of the other License fields is entered. The Expiration Date cannot be before the Effective Date. This must be entered as a valid value in the format 'MM/DD/YYYY'.

Issuing State – Select the State the license is issued from using the drop-down. Issuing State is a required field if any one of the other License fields is entered.

Description – Optional license description. This free form field allows up to 50 characters.

Type – Select the appropriate value for the license type. Valid values are Primary or Secondary. Type is a required field if any one of the other License fields is entered. Provider types or specialties that require a license must add required licenses with a Type of Primary. Visit the Information by Provider Type web page, click the Provider Type drop-down and reference the Required Attachments for more information on required licenses. Non-required licenses may be added with a Type of Secondary.

Certification Section

Specialty – Select the Specialty from the drop-down. Typical values could include Physician, Pharmacy, Nursing Facility, etc. This field is required.

Certificate Number - Enter the Certification number. This field allows 20 alphanumeric characters. This field is required.

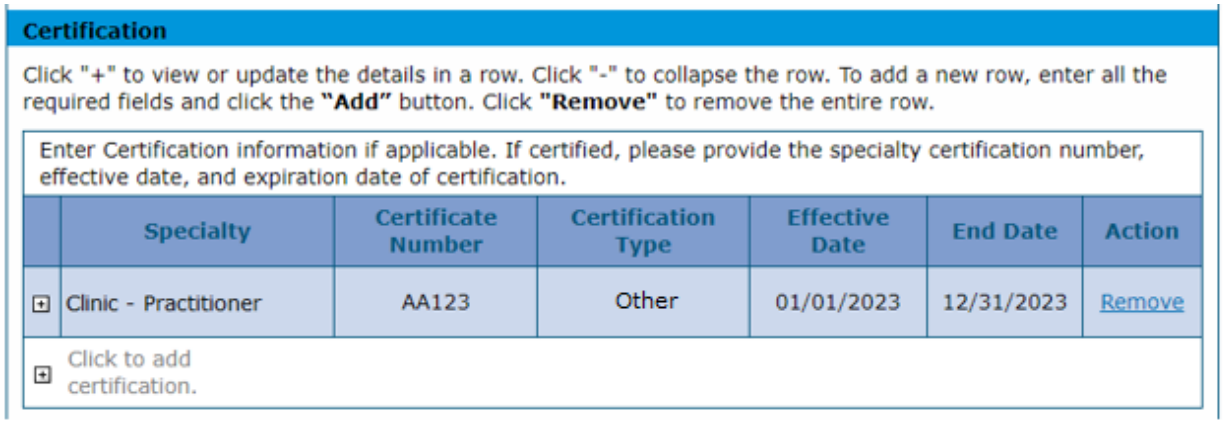
Certification Type – Select the appropriate Certification Type from the drop-down. Values could include Accreditation, National Specialty Board, Other, Tax Exempt, etc. This field is required.

Effective Date – Enter the Effective date for the certification. This field allows eight numeric characters in MM/DD/YYYY format. This is a required field if the certificate number is entered.

End Date – Enter the End date for the certification. This field allows eight numeric characters in MM/DD/YYYY format. End Date cannot be before Effective Date. This field is required.

Select the 

button to add the certificate information. If additional certifications need to be entered, click '**+**' to add certificates:



Medicare Participation Section

Medicare # – Enter the Medicare Number assigned by the Federal government to the provider. This field allows ten alphanumeric characters. Medicare Number is a required field if any one of the other Medicare fields is entered.

Effective Date (Medicare Number) – Enter the effective date of the Medicare Number. This is the date the Medicare contractor received the signed and dated Certification Statement. This field allows eight numeric characters. The Effective Date is a required field if one of the other Medicare fields is entered. This must be entered as a valid value in the format 'MM/DD/YYYY'.

Medicare Type – Select the Medicare Type associated with the Medicare Number from the drop-down. Medicare Type is required if any one of the other Medicare fields is entered. Typical values could include Medicare Part A, Medicare Part B, etc.

CLIA Certification Section or DEA Section

CLIA Certification Section

CLIA # – For Group, Facility or Atypical providers, enter the Clinical Laboratory Improvement Amendment (CLIA) certification number assigned to the provider. The field allows up to ten numeric characters. CLIA # is a required field if any CLIA field is entered. A copy of the CLIA certificate is required in attachments. The CLIA data panel should not be displayed in applications for individuals.

Effective Date (CLIA) – Enter the effective date for the CLIA certification number. Effective Date is a required field if a CLIA # is entered. This field allows eight Numeric characters. This must be entered as a valid value in the format 'MM/DD/YYYY'.

End Date (CLIA) – Enter the end date for the CLIA certification number. If there is no end date for the CLIA certification, enter 12/31/2299. This field allows eight numeric characters. The End Date is a required field if one of the other CLIA fields is entered. This must be entered as a valid value in the format 'MM/DD/YYYY'.

DEA Section

DEA # – Enter the DEA (Drug Enforcement Agency) number that is assigned to the provider. This field allows nine alphanumeric characters. DEA Number is required if Effective Date is entered.

Effective Date (DEA) – Enter the effective date for the DEA Number. Effective Date is a required field if a DEA Number is entered. This field allows eight Numeric characters. This must be entered as a valid value in the format 'MM/DD/YYYY'.

Other Identifier(s)

Managed Care Organizations

Health Plan Identifier (HPID) – Enter the Health Plan ID for the provider. The HPID is only for Managed Care Organizations. This field allows up to 15 alphanumeric characters.

Pharmacy Enrollments

NCPDP Provider ID Number – Enter the NCPDP Provider ID Number of the provider. This field allows the ten alphanumeric characters. This is an optional field and is applicable to Pharmacy enrollments only.

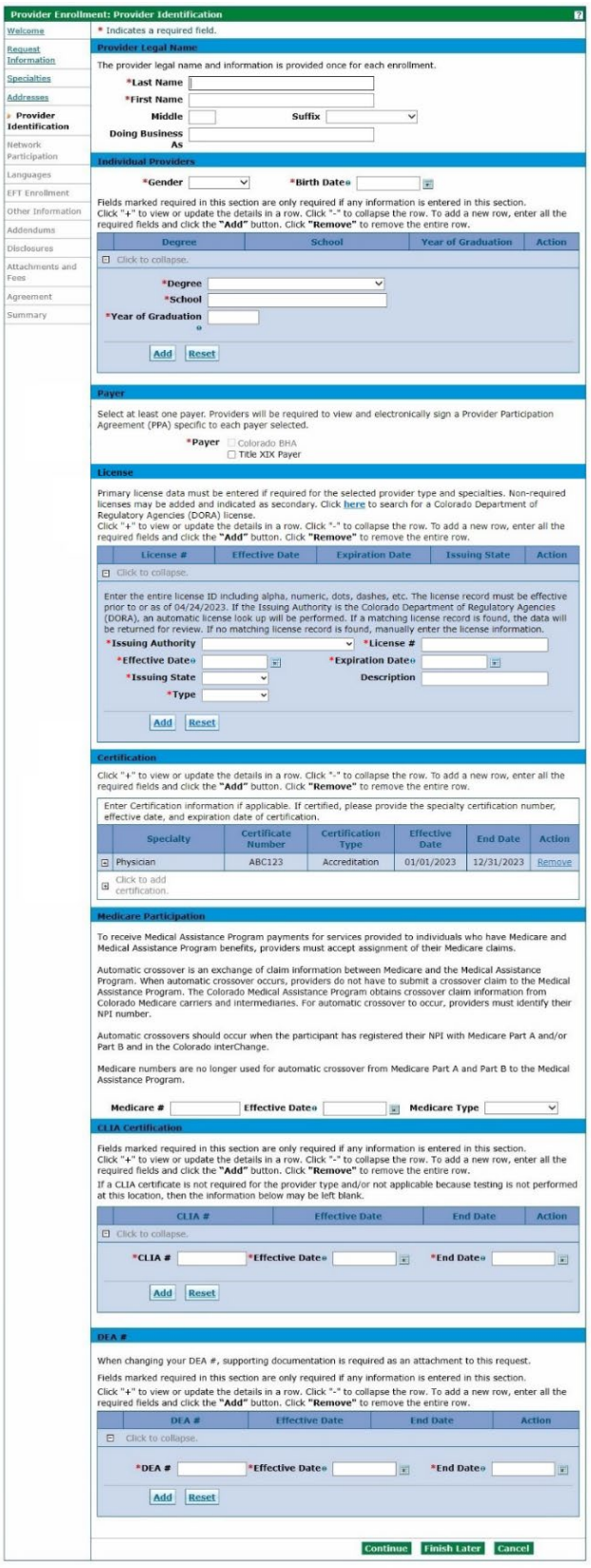
Pharmacy Classification – Enter the classification of the Pharmacy ID. List includes values such as Chain, Federal Government, Hospital, etc.

When the panel is complete, select "**Continue**", "**Finish Later**", or "**Cancel**".

Billing Individuals, Individual within Group and OPR

Below is an example of the panel for an Individual within Group Provider Type selection.

Provider Identification Panel – Individual within Group



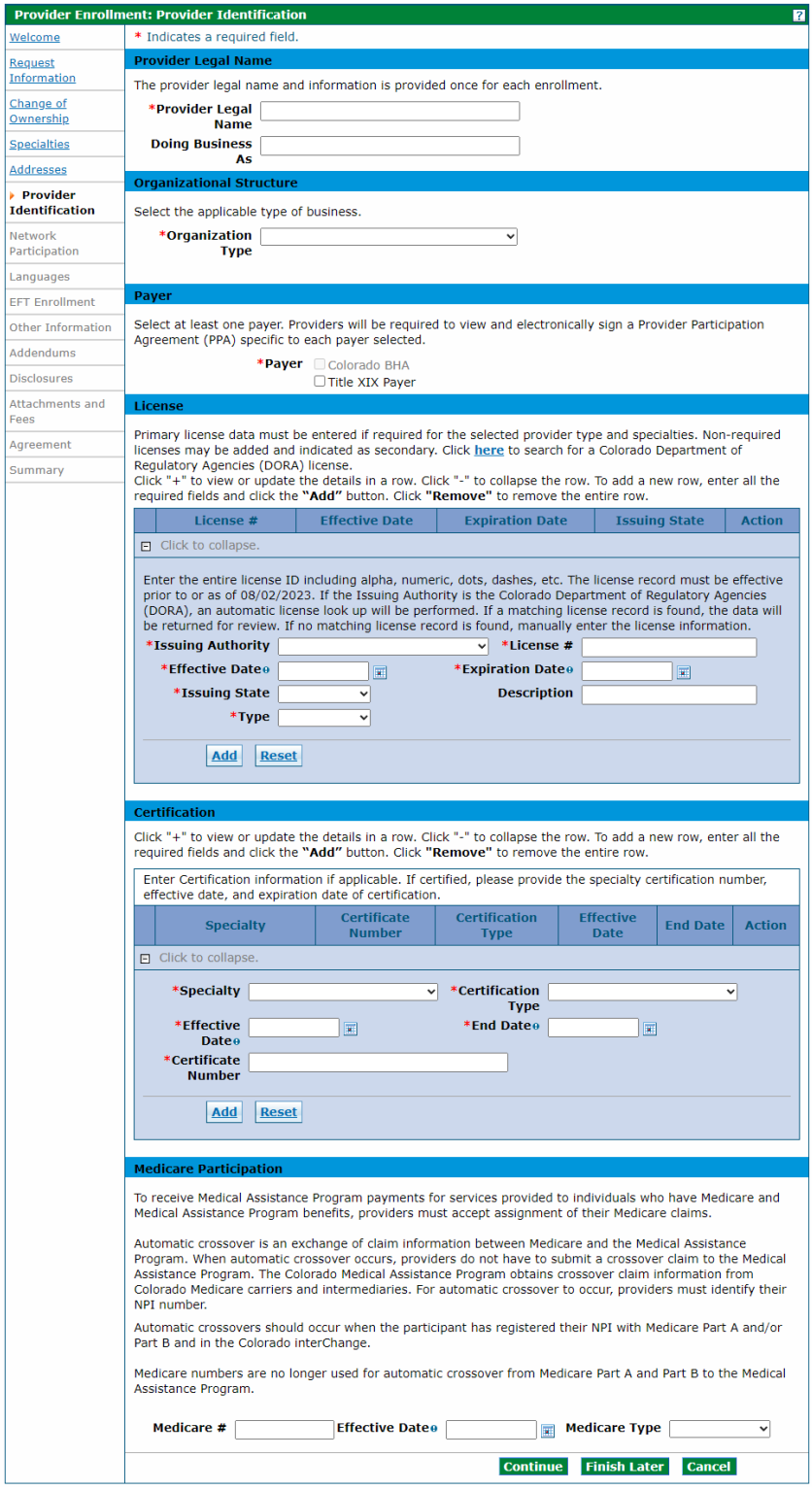
Fields marked required in this section are required only if information is entered in this section.

A license may be required depending on the Provider Type and/or Specialty selected.

Facility and Atypical

Below is an example of the panel for an Atypical Provider Type selection.

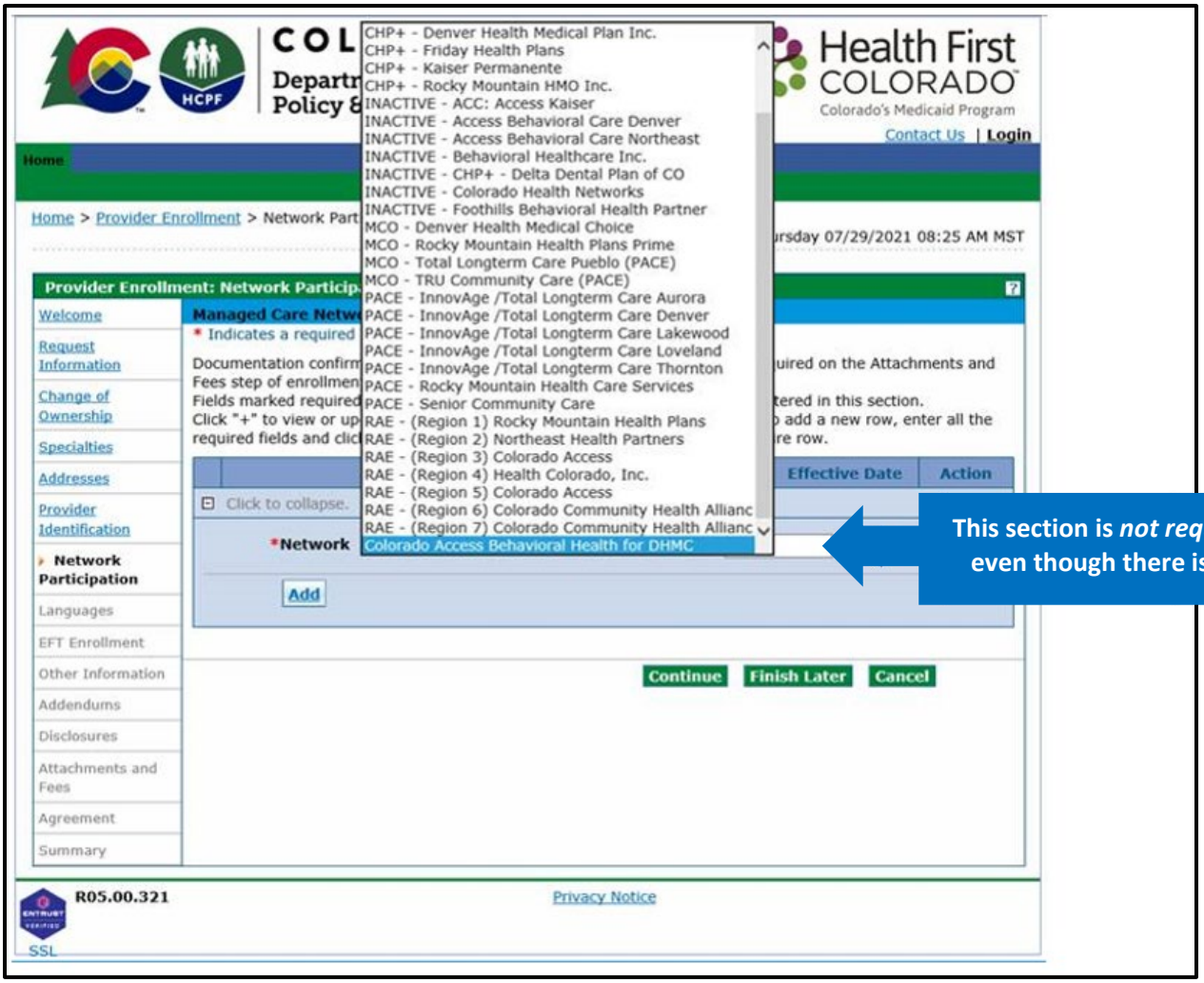
Provider Identification Panel – Atypical



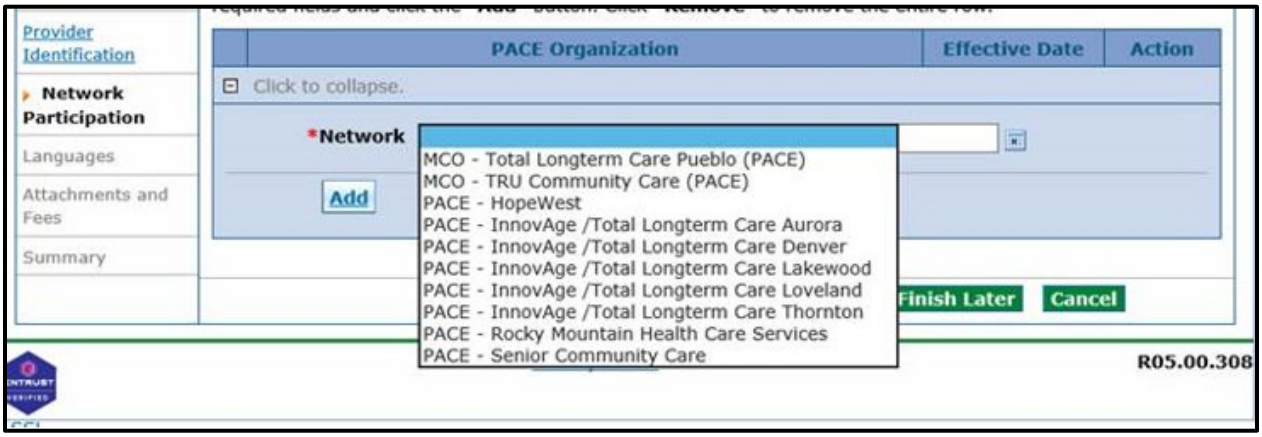
If unsure of the organization type, this information may be found by performing a records search on the Secretary of State website.

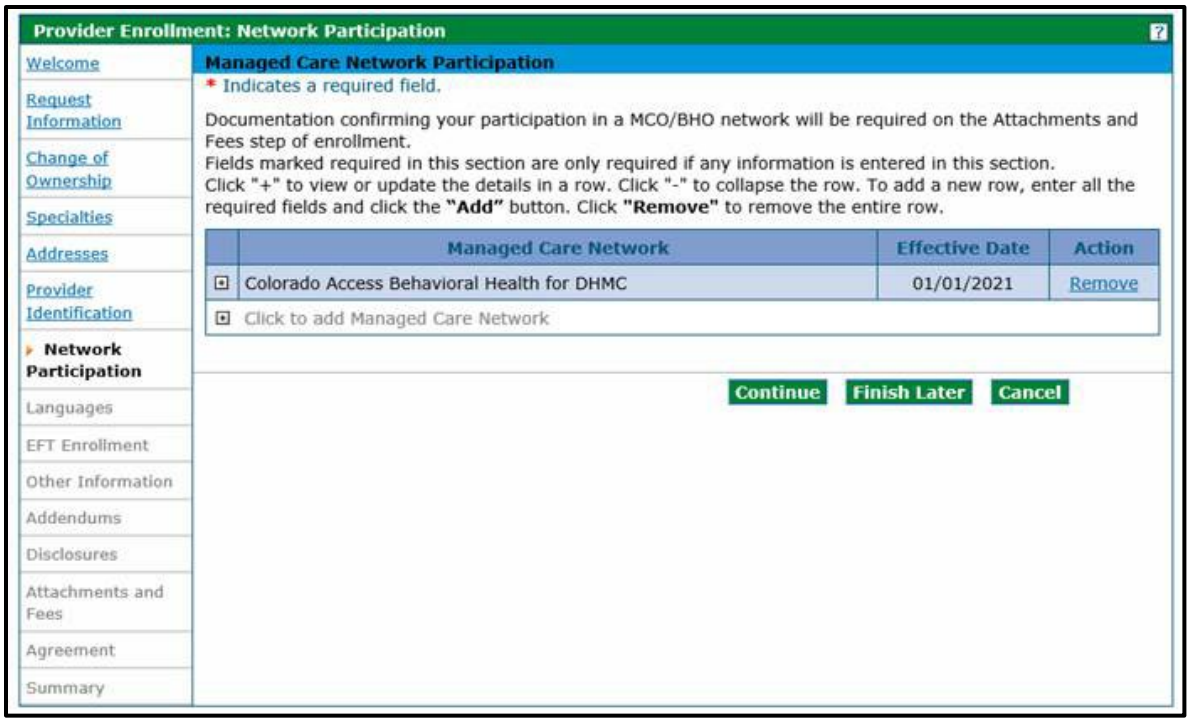
A license may be required depending on the Provider Type and/or Specialty selected.

Network Participation Panel



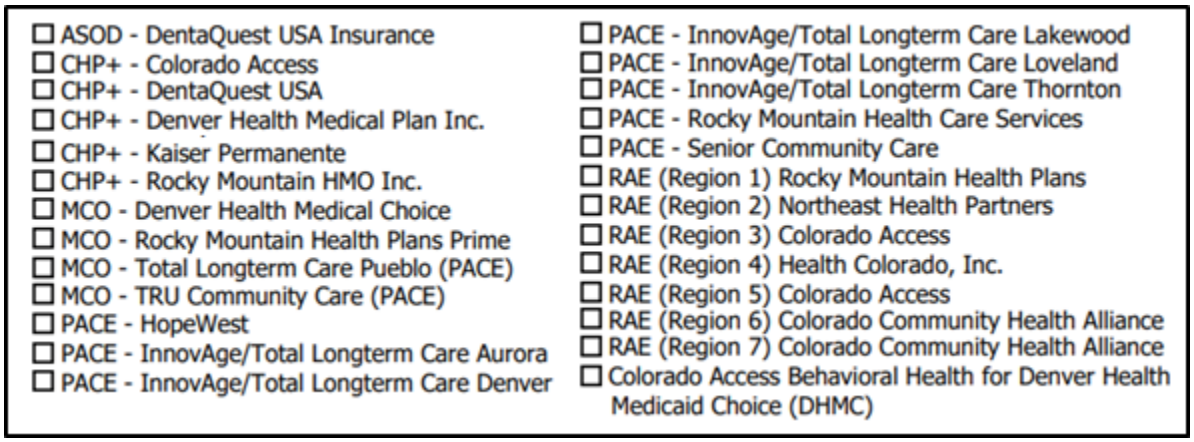
Selection for PACE-Only Subcontractors





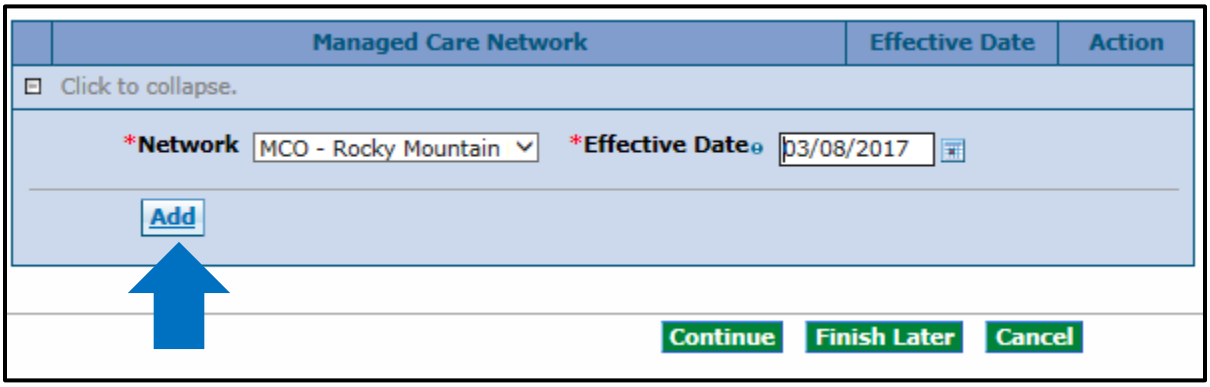
The Network Participation panel is where providers may enter any medical networks that they participate in. Adding a network option here will not create an enrollment into that network. Additionally, a copy of the signed contract or a completed Network Participation Form, available from the Provider Forms web page under the Provider Enrollment and Update Forms drop-down, must be scanned and attached on the "Attachments and Fees" panel.

Using the drop-down, providers may select from available Colorado networks. The networks available for selection at this time are:



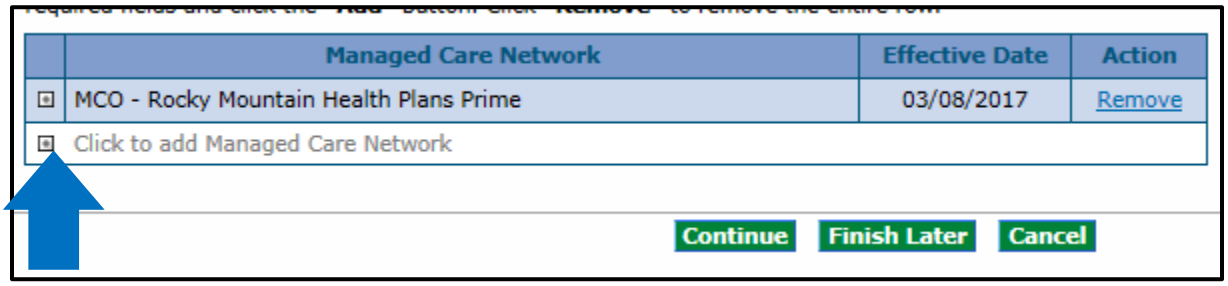
Once a network and its effective date have been chosen, click the Add button to add it to the list.

Network Participation Panel – MCO/RAE Add Network



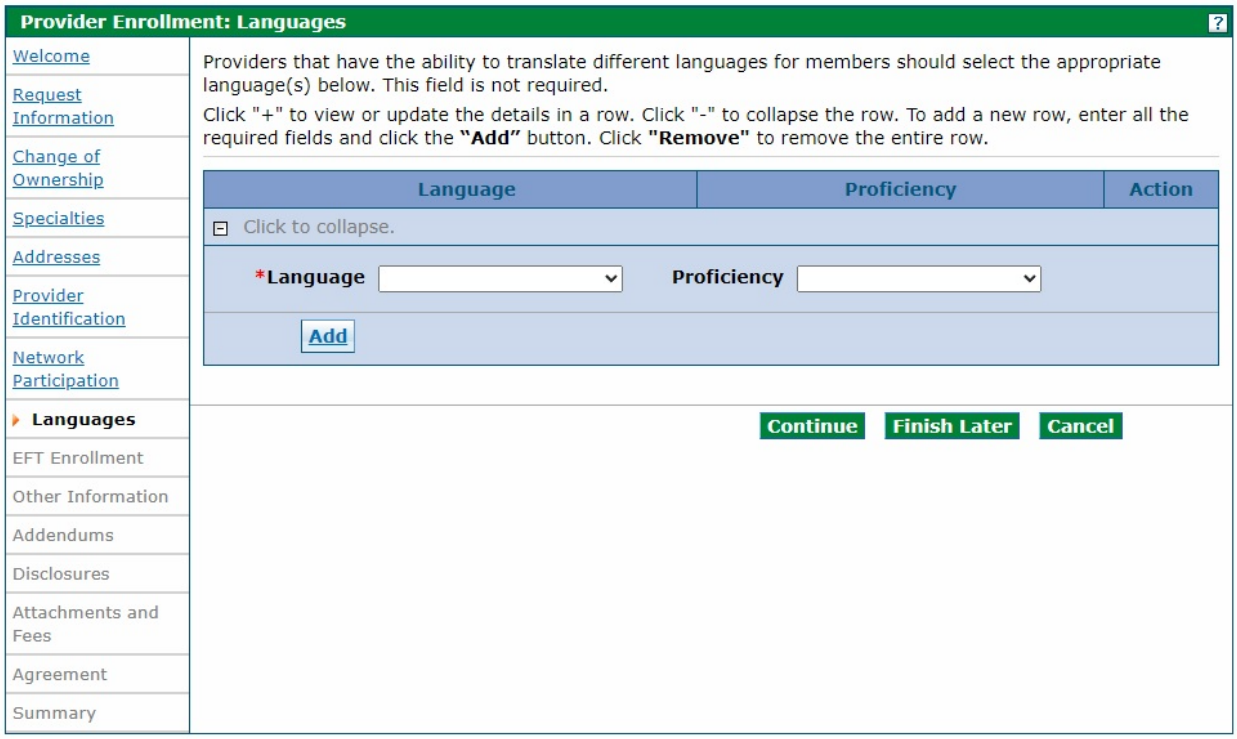
If a provider is a member of more than one network, click the "**+**" to add another network. Repeat the same steps as above to do this until this panel of the application is complete.

Network Participation Panel – MCO/BHO Network Add another MCO Network



When the panel is complete, select "**Continue**", "**Finish Later**", or "**Cancel**".

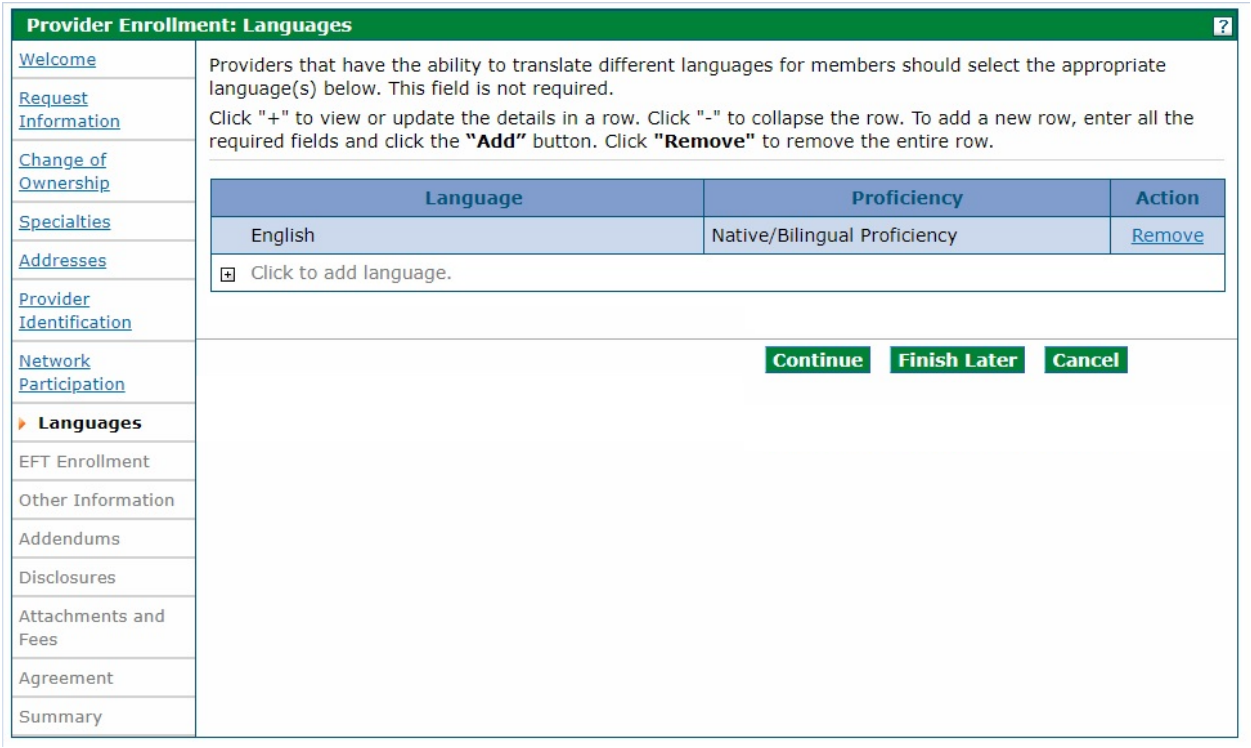
Languages Panel



On this panel, the user may enter any languages and the proficiency level spoken within the office or facility. The user may add as many as needed. This information will be shown in the Colorado Medicaid Provider Look-up. There are currently 60 languages available to choose from.

After each language is selected, click the **"Add"** button. The screen will update and add the selected item to the list of languages. If a language needs to be removed, click the "**Remove**" link on the right of the screen. Add as many languages as needed to reflect the enrolling provider's capabilities.

Languages Panel – Add additional Language



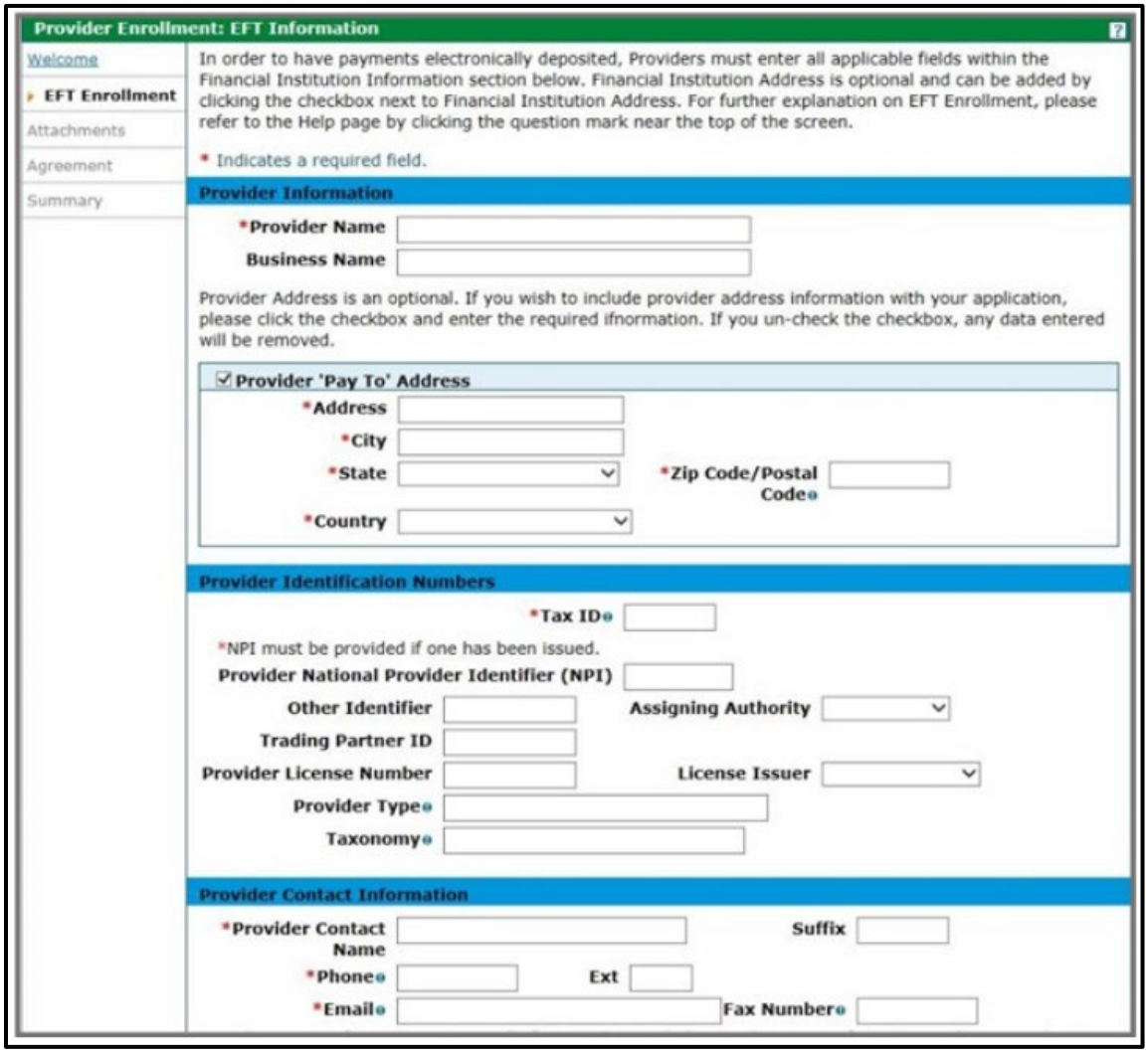
When the panel is complete, select "**Continue**", "**Finish Later**", or "**Cancel**".

Electronic Funds Transfer (EFT) Enrollment Panel

Note: The Electronic Funds Transfer (EFT) panel will not display for PACE-Only Subcontractor provider enrollment types.

The following comprehensive list describes the fields on the EFT Enrollment panel:

EFT Enrollment Panel – Part 1



A scanned copy of a bank letter or a voided business check needs to be added on the “Attachments and Fees” panel.

This panel collects information needed for direct deposit of claims reimbursement into a bank account via Electronic Funds Transfer (EFT). EFT allows quicker access to claim payments by depositing them directly to the bank account.

Not all enrollment types will see this panel. If the user is an Individual within a Group, the user will not see this panel as the Group submits claims on behalf of the individual and would be responsible for submitting the information for this panel. If the user is an OPR provider, the user will not see this panel as an OPR provider does not submit claims for payment.

Provider Information Section

Provider Name – Complete legal name of institution, corporate entity, practice, or individual provider. If applicable, this field is display only and supplied by the value from the Provider Identification panel. This field is prepopulated with the value entered previously in the application.

Business Name – The name under which the business or operation is conducted. If applicable, this field is display only and supplied by the value from the Provider Identification panel. This field is prepopulated with the value entered previously in the application.

Provider Pay To Address Section

Address – Enter the address associated to the provider. If applicable, this field is display only and supplied by the value from the 'Pay To' address panel.

City – Enter the city associated to the provider address. If applicable, this field is display only and supplied by the value from the 'Pay To' Address page. This field allows up to 30 alphanumeric characters.

State – State associated to the provider's 'Pay To' address.

Zip Code / Postal Code – Zip Code associated to the provider address. If applicable, this field is display only and supplied by the value from the 'Pay To' Address page.

Country – Country code associated to the provider's address. This field is supplied by the values from the 'Pay To' Addresses page.

Provider Identification Numbers Section

Tax ID – A Federal Tax Identification Number used to identify the business entity. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows nine numeric characters.

Provider National Provider Identifier (NPI) (Provider Identification Numbers) – Unique identification number for the provider. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten numeric characters.

Other Identifier – Additional provider identifier. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten alphanumeric characters.

Assigning Authority – Organization that issues and assigns the additional provider identifier. If applicable, this field is display only and supplied by the value from the Request Information page. Use the drop-down to make a selection. Assigning Authority is a required field if Other Identifier is entered.

Trading Partner ID –Provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor. This field allows ten alphanumeric characters and is optional.

Provider License Number – Provider's License Number. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows 20-alphanumeric characters.

License Issuer – Entity that issued the provider's license number. This field allows up to 30 alphanumeric characters. License Issuer is supplied by the Request Information page.

Provider Type – Type of provider. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows 50 alphanumeric characters.

Taxonomy Code – Provider's Taxonomy Code. The code set is structured into three distinct levels including provider type, classification and area of specialization. If applicable, this field is display only

and supplied by the value from the Request Information page. This field allows ten alphanumeric characters.

Provider Contact Information Section

Provider Contact Name – Name of the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows up to 70 alphanumeric characters.

Suffix (Provider Contact) – Suffix of the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows up to 30 alphanumeric characters.

Phone (Provider Contact) – Phone number for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten numeric characters.

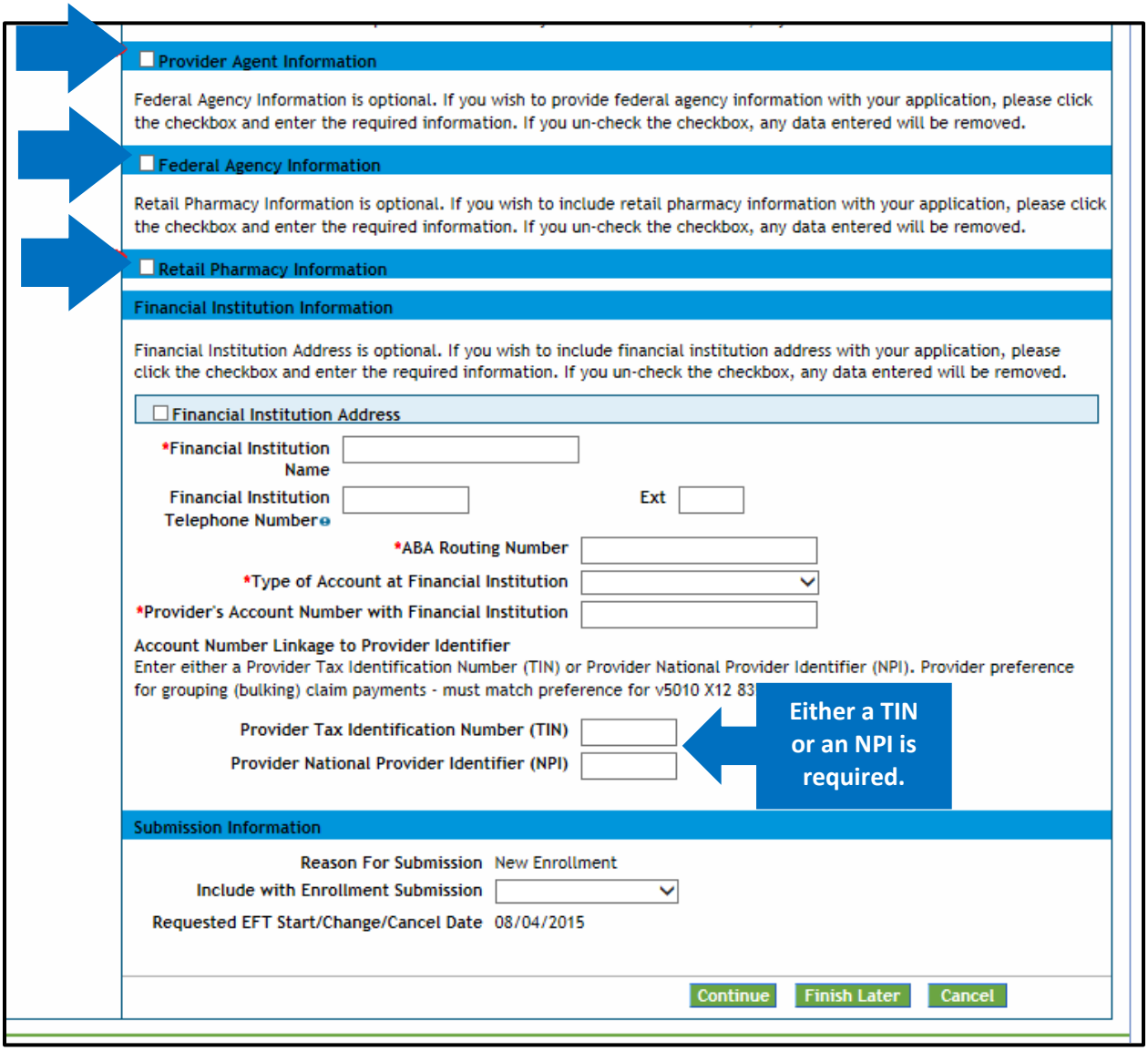
Ext (Provider Contact) – Telephone Number Extension for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows four numeric characters.

Email (Provider Contact) – Email Address for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows 50 alphanumeric characters. Enter a valid email address with 'name@domain' format.

Fax Number (Provider Contact) – Fax Number for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten numeric characters. Enter a fax number in the format '999-999-9999'.

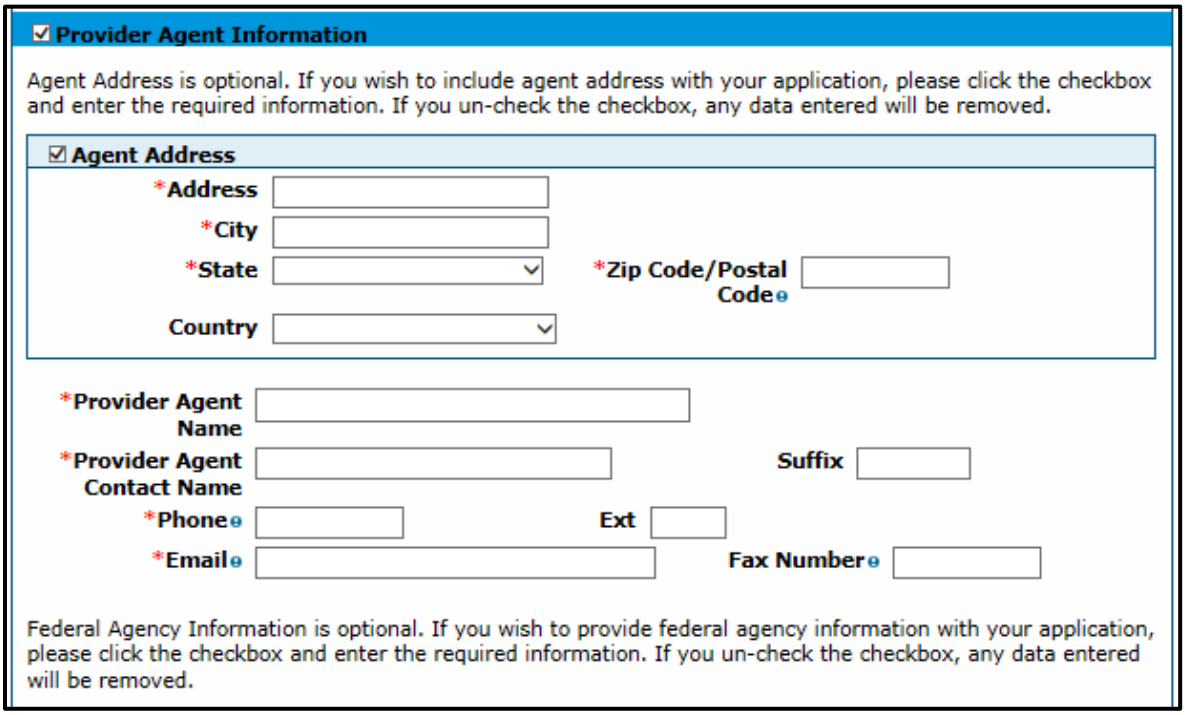
This panel also includes several optional sections that can be completed during the Enrollment process. These sections are indicated by blue arrows on the panel below.

EFT Enrollment Panel – Part 2



Clicking on the white checkboxes will open each optional area. This information is not required but can be entered if desired. Unchecking the box will close this section and remove any information entered in these fields.

Provider Agent Information Section



Agent Address – Enter the number and street name of the agent address. This field allows up to 55 alphanumeric characters. Enter the number and street name of the agent address. This field is only required when the Agent Address check box has been checked.

City – Enter the city associated to the agent address. Enter as 30 Alphanumeric characters. This field is only required when the Agent Address check box has been checked.

State – State associated to the agent address. Use the drop-down to make a selection. This field is only required when the Agent Address check box has been checked.

Zip Code / Postal Code – Zip Code associated to the agent address. This field allows nine numeric characters. This field is only required when the Agent Address check box has been checked.

Country – Country codes associated to the agent address. Use the drop-down to make a selection. This field is only required when the Agent Address check box has been checked.

Provider Agent Name – Name of the agent. This field allows up to 70 alphanumeric characters. This field is only required when the Provider Agent Information check box has been checked.

Provider Agent Contact Name – Enter the name of the agent contact. This field allows up to 70 alphanumeric characters. This field is only required when the Provider Agent Information check box has been checked.

Suffix (Agent Contact) – Suffix of the agent contact. This field allows up to 30 alphanumeric characters. This field is only required when the Agent Address check box has been checked.

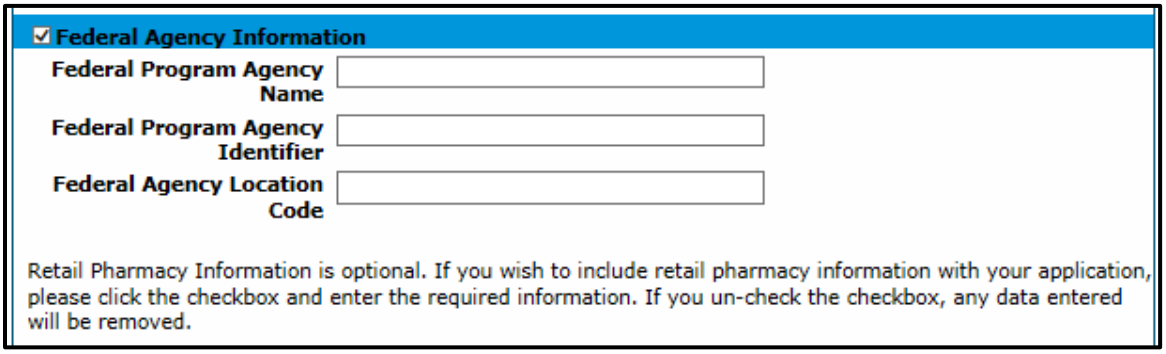
Phone (Agent Contact) – Phone number for the agent contact. This field allows ten numeric characters. Enter a phone number in the format '999-999-9999'. This field is only required when the Provider Agent Information check box has been checked.

Ext (Agent Contact) – Telephone Number Extension for the agent contact. This field allows four numeric characters. This field is only required when the Agent Address check box has been checked.

Email (Agent Contact) – Email Address for the agent contact. This field allows up to 50 alphanumeric characters. Enter a valid email address with 'name@domain' format. This field is only required when the Provider Agent Information check box has been checked.

Fax Number (Agent Contact) – Fax Number for the agent contact. Enter as 10-Numeric characters. Enter a fax number in the format '999-999-9999'. This field is required.

Federal Agency Information Section

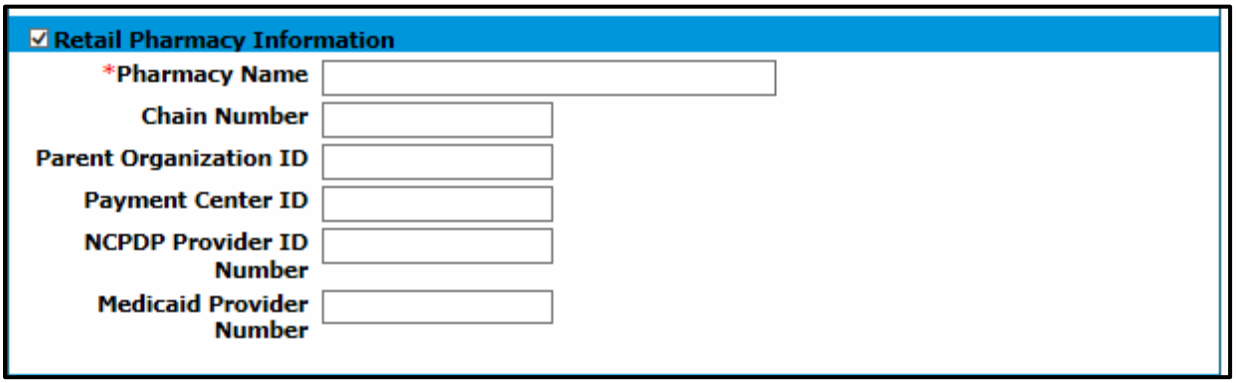


Federal Program Agency Name – Name of the Federal Program Agency. This field allows up to 70 alphanumeric characters.

Federal Program Agency Identifier – Identifier of the Federal Program Agency. This field allows up to ten alphanumeric characters.

Federal Agency Location Code – Location Code of the Federal Program Agency. This field allows up to 25 alphanumeric characters.

Retail Pharmacy Information Section



Pharmacy Name – Enter the Pharmacy Name. This field allows up to 70 alphanumeric characters. This field is only required when the Retail Pharmacy Information check box has been checked.

Chain Number – Enter the identification number assigned to the entity allowing linkage for a business relationship, i.e., chain, buying groups or third-party contracting organizations. This may also be known as Affiliation ID or Relation ID. This field allows five alphanumeric characters.

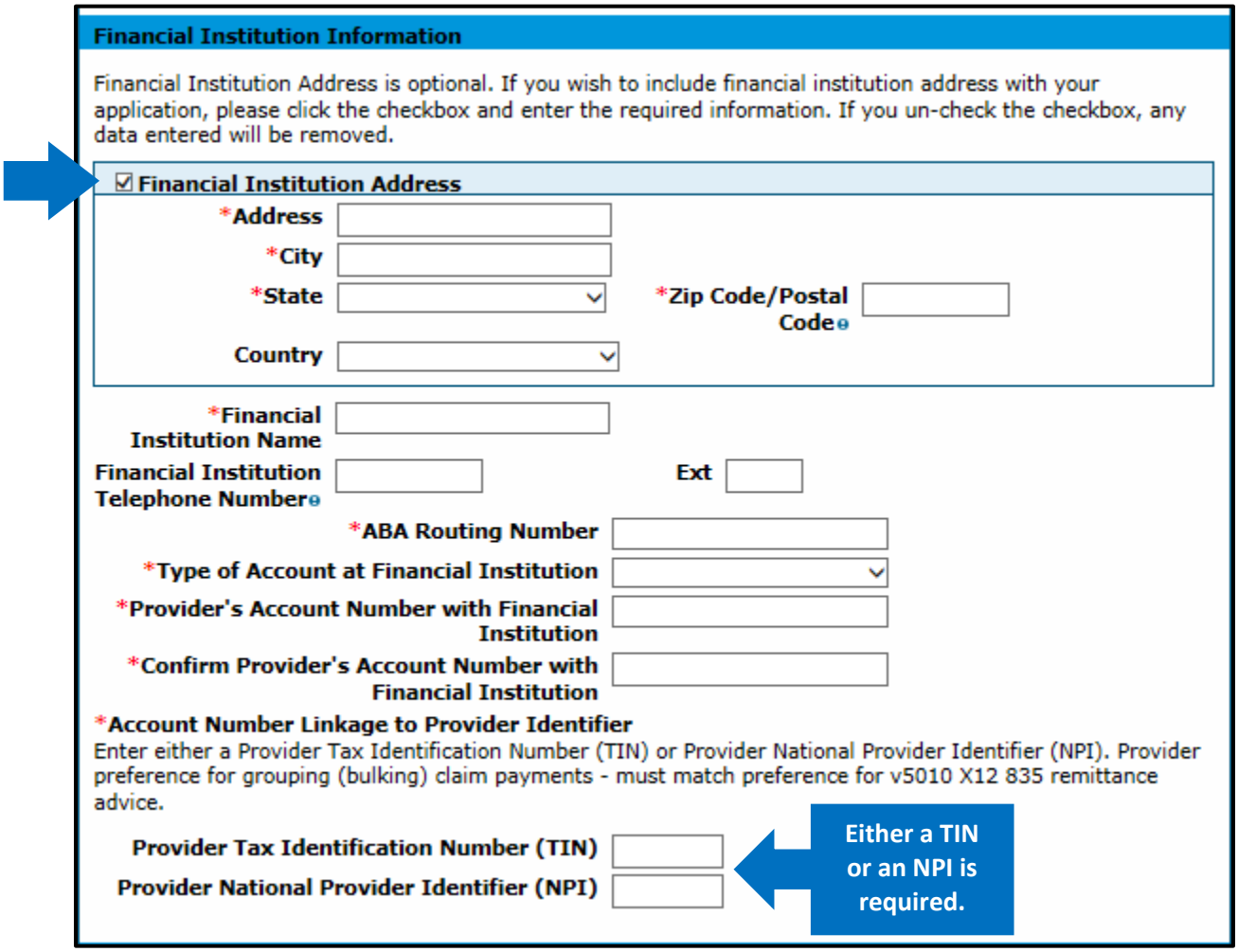
Parent Organization ID – Headquarter information for chains, buying groups or third-party contracting organizations where multiple relationship entities exist and need to be linked to a common organization such as common ownership for several chains. This field allows ten alphanumeric characters.

Payment Center ID – The assigned payment center identifier associated with the provider/corporate entity. This field allows ten alphanumeric characters.

NCPDP Provider ID Number – The National Council for Prescription Drug Programs (NCPDP) assigned unique identification number. This field allows seven alphanumeric characters.

Medicaid Provider Number – A number issued to a provider by the U.S. Department of Health and Human Services through state health and human services agencies. This field allows ten alphanumeric characters.

Financial Institution Information Section



Within the Financial Institution section of the Enrollment page, there are several fields that are indicated with a red asterisk. These are required fields that must be completed. Additionally, the user has the option to enter the Financial Institution's address information. This can be done by clicking the white checkbox indicated by a blue arrow on the panel above.

Address (Financial Institution) – Enter the number and street name of the financial institution address. This field allows up to 55 alphanumeric characters. This field is only required when the Financial Institution Address check box has been checked.

City (Financial Institution) – Enter the city associated to the financial institution address. This field allows up to 30 alphanumeric characters. This field is only required when the Financial Institution Address check box has been checked.

State (Financial Institution) – State associated to the financial institution address. Use the drop-down to make a selection. This field is only required when the Financial Institution Address check box has been checked.

Zip Code / Postal Code (Financial Institution) – Zip Code associated to the financial institution address. This field allows nine numeric characters. This field is only required when the Financial Institution Address check box has been checked.

Country (Financial Institution) – Country codes associated to the financial institution address. Use the drop-down to make a selection. This field is only required when the Financial Institution Address check box has been checked.

Financial Institution Name – Name of the provider's financial institution. This field allows up tp 39 alphanumeric characters. This field is required.

Financial Institution Telephone Number – Phone number for the provider's financial institution. This field allows ten numeric characters. Enter a phone number in the format '999-999-9999'. This field is only required when the Financial Institution Address check box has been checked.

Ext (Financial Institution) – Telephone Number Extension for the provider's financial institution. This field allows four numeric characters. This field is only required when the Financial Institution Address check box has been checked.

ABA Routing Number – Enter as the 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited. This field allows nine numeric characters. This field is required.

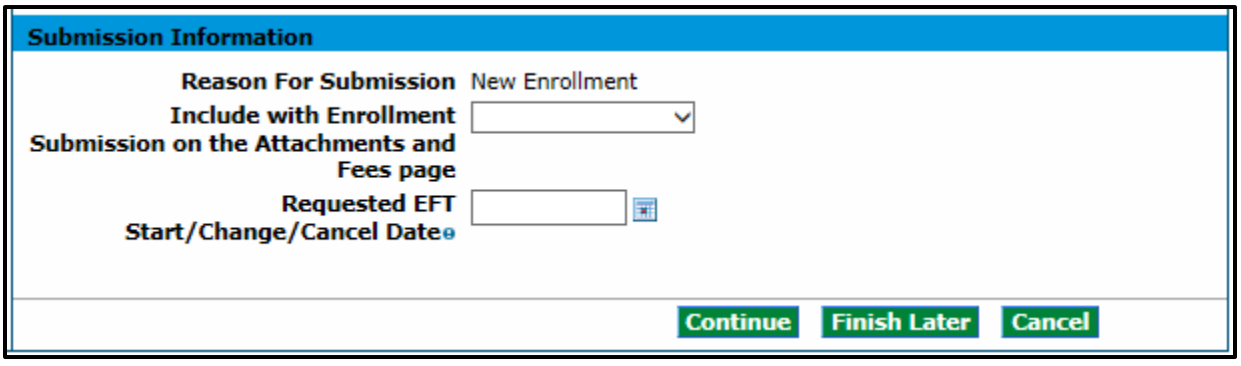
Type of Account at Financial Institution – The type of account the provider will use to receive EFT payments, e.g., Checking, Savings. Use the drop-down to make a selection. Type of Account at Financial Institution is a required field.

Provider's Account Number with Financial Institution – Provider's account number at the financial institution to which EFT payments are to be deposited. This field allows ten alphanumeric characters. This field is required.

Provider Tax Identification Number (TIN) – (Financial Institution Information) – Federal Tax Identification Number used to identify a business entity. This field allows nine numeric characters. Either a provider's NPI or TIN is required.

Provider National Provider Identifier (NPI) (Financial Institution Information) - Unique identification number for the provider. This field allows ten numeric characters. Either a provider's NPI or TIN is required.

Submission Information Section



Reason For Submission – Reason for the EFT enrollment. "New Enrollment" is the only option and is what will populate here.

Include with Enrollment Submission – The bank account verification document type needs to be attached as part of the enrollment application. Use the drop-down to make a selection between "Bank Letter" or "Voided Check". The user will need to attach the bank letter or the voided check in the "Attachment and Fees" panel.

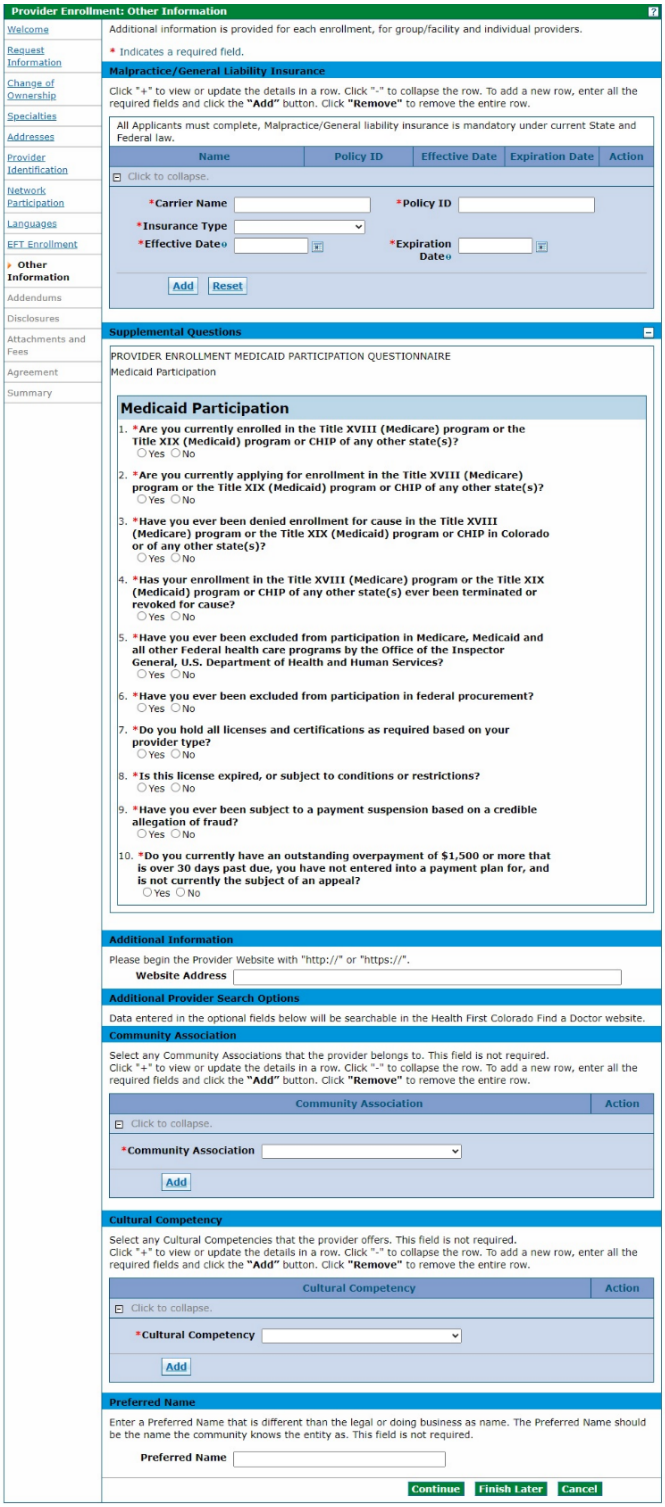
Requested EFT Start/Change/Cancel Date – Date on which the requested action is submitted. As part of the enrollment application this field is display only and defaulted to the current date. This field allows eight numeric (MM/DD/YYYY) characters.

When the panel is complete, select "**Continue**", "**Finish Later**", or "**Cancel**".

Other Information Panel

Note: The Other Information panel will not display for PACE-Only Subcontractor provider enrollment types.

The example below displays a Group enrollment type. The screen may look similar to the following:



The Other Information panel is where the user may enter any other additional information as applicable to the practice or facility. The Provider Enrollment tool will automatically present the appropriate questions based on the Enrollment Type chosen earlier in the process. This can include degrees, schools attended, number of Medicaid-eligible or certified/licensed beds, and liability insurance information.

An example of each Other Information panel is listed in the sections directly following this section. Below is a comprehensive list of all the Other Information fields that could be present:

Malpractice/General Liability Insurance Section

Carrier Name – Enter the name of the insurance carrier. This field allows up to 25 alphanumeric characters. This field is required.

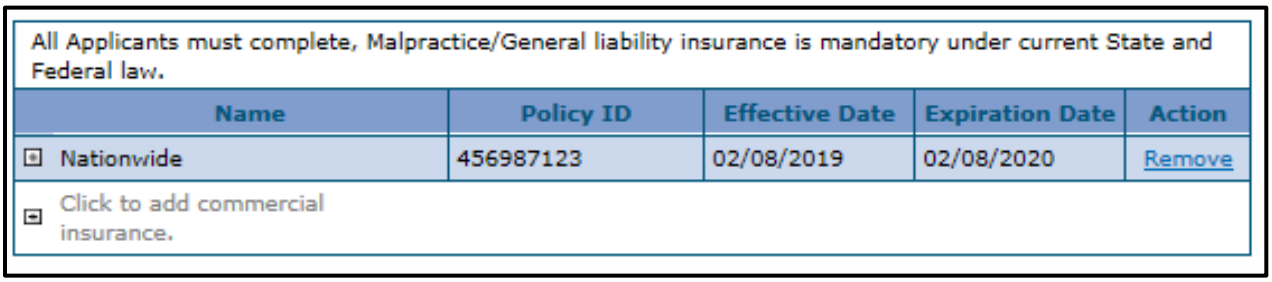
Policy ID – Enter the Policy ID for the insurance carrier. This field allows up to 20 alphanumeric characters. This field is required.

Effective Date – Enter the Effective Date for the provider insurance. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.

Expiration Date - Enter the Expiration Date for the provider insurance. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.

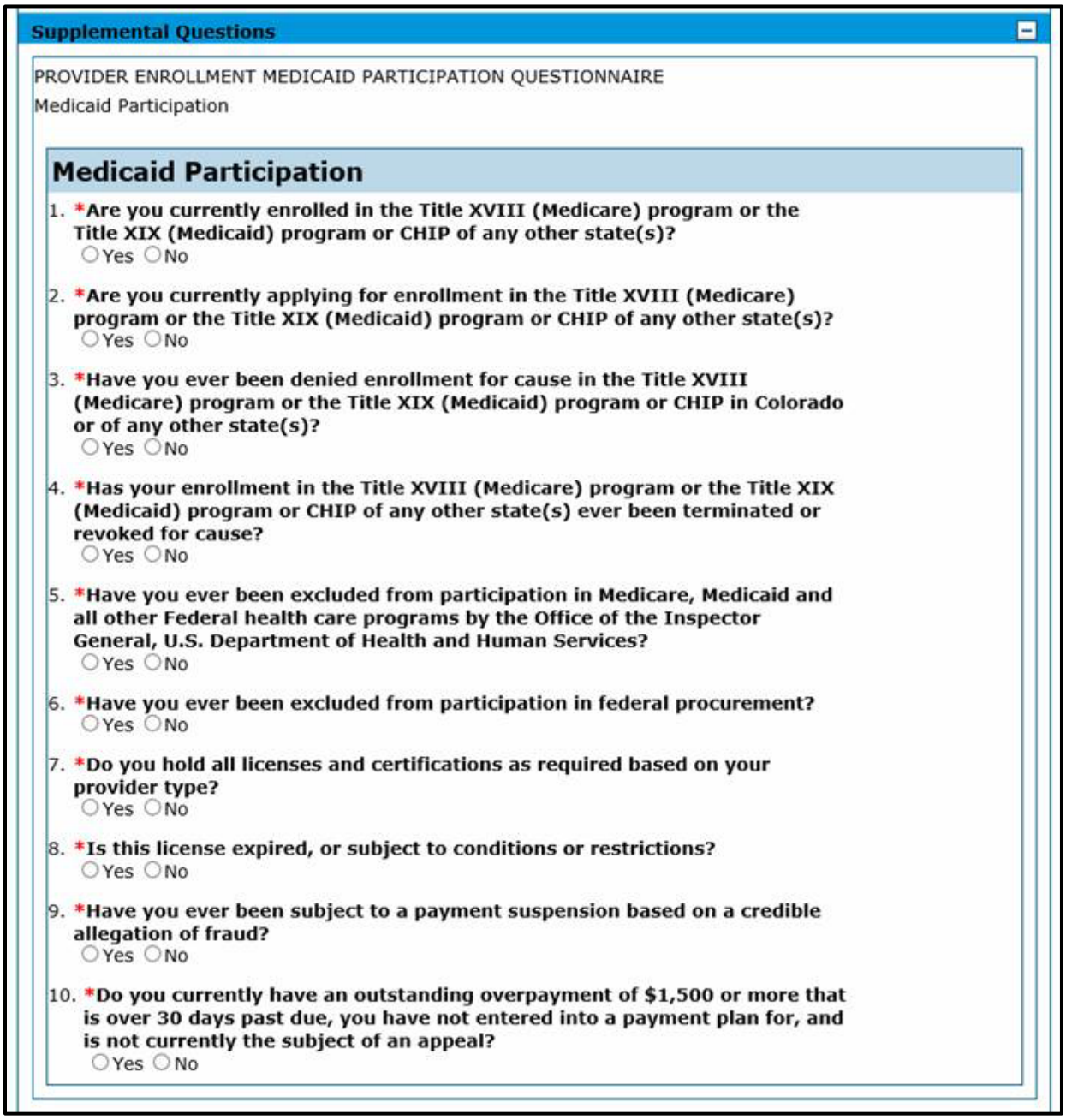
Select the 

button to add the policy. If additional policies need to be entered, click '**+**' to add policies:

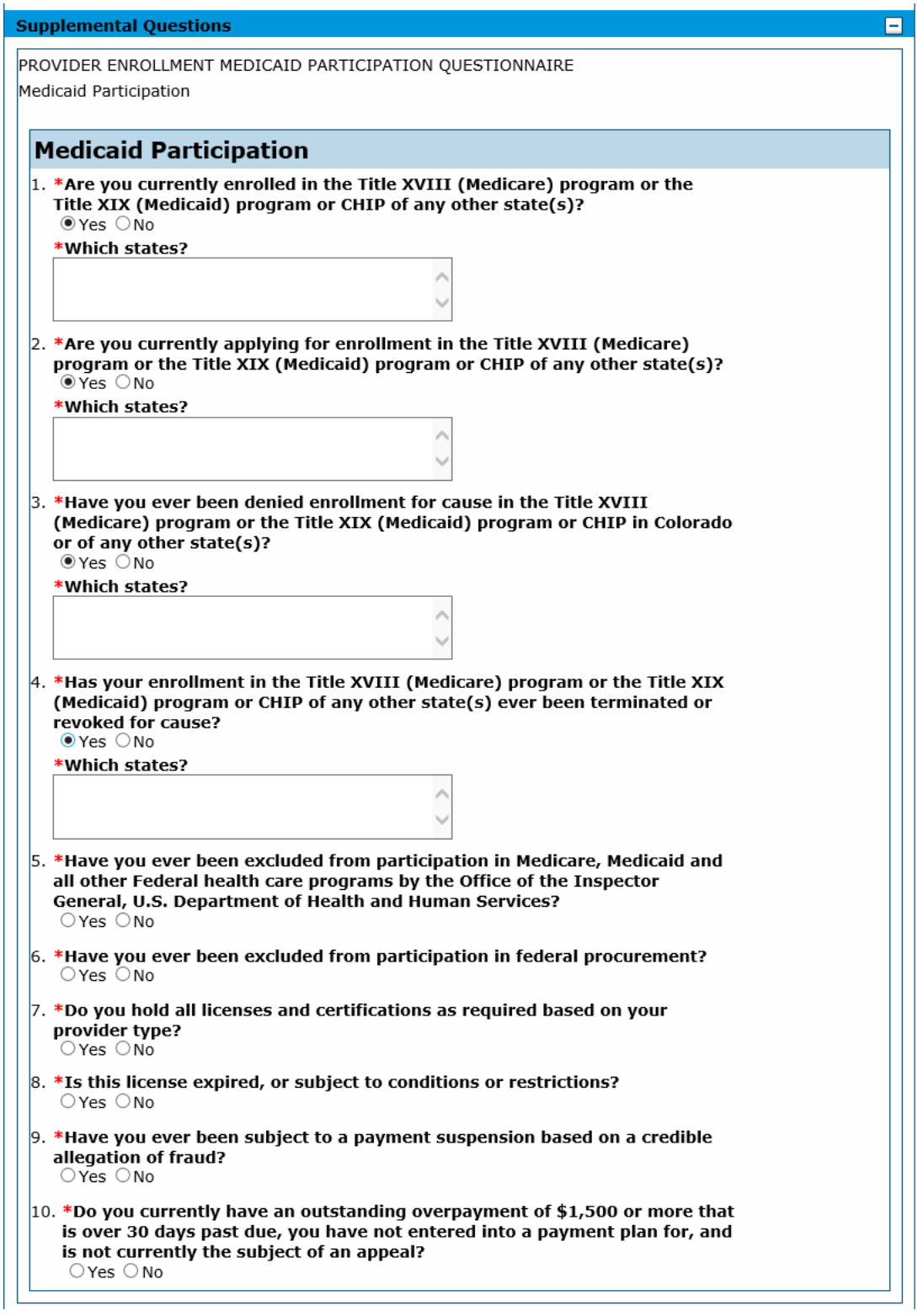


Supplemental Questions Section

Select Yes or No for the Supplemental Questions. This field is required.



Answering 'Yes' to questions 1-4 will open a required text box to elaborate on the answer.



Supplemental Questions

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE
Medicaid Participation

Medicaid Participation

1. ***Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   (•) Yes ( ) No
   ***Which states?**

2. ***Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   (•) Yes ( ) No
   ***Which states?**

3. ***Have you ever been denied enrollment for cause in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)?**
   (•) Yes ( ) No
   ***Which states?**

4. ***Has your enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated or revoked for cause?**
   (•) Yes ( ) No
   ***Which states?**

5. ***Have you ever been excluded from participation in Medicare, Medicaid and all other Federal health care programs by the Office of the Inspector General, U.S. Department of Health and Human Services?**
   ( ) Yes ( ) No

6. ***Have you ever been excluded from participation in federal procurement?**
   ( ) Yes ( ) No

7. ***Do you hold all licenses and certifications as required based on your provider type?**
   ( ) Yes ( ) No

8. ***Is this license expired, or subject to conditions or restrictions?**
   ( ) Yes ( ) No

9. ***Have you ever been subject to a payment suspension based on a credible allegation of fraud?**
   ( ) Yes ( ) No

10. ***Do you currently have an outstanding overpayment of $1,500 or more that is over 30 days past due, you have not entered into a payment plan for, and is not currently the subject of an appeal?**
    ( ) Yes ( ) No

Additional Information Section

Web Site Address – Enter the Provider's web site URL. This field allows up to 55 alphanumeric characters. This field is not required.

Institutional Bed Information Section

A facility enrollment type will have the following section in these panels:

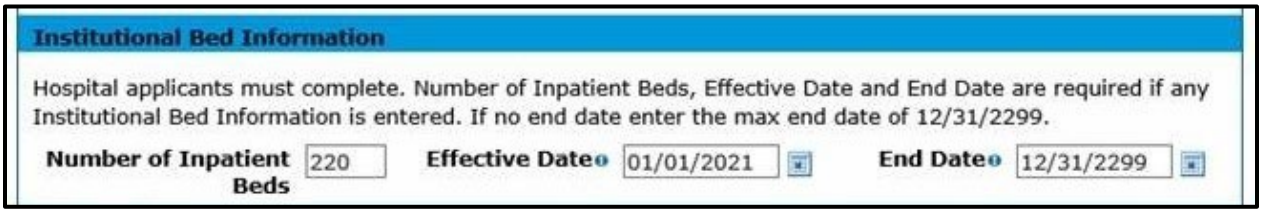
Assisted Care Facilities

Number of ICF Beds – Enter the number of beds at the nursing facility for Intermediate Care Facilities (ICF) patients. This field allows five numeric characters. This field is required.

Effective Date – Enter the Effective date of the hospital bed. Enter eight characters in MM/DD/YYYY format. This field is required.

End Date – Enter the End date of the hospital bed. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.

Hospitals

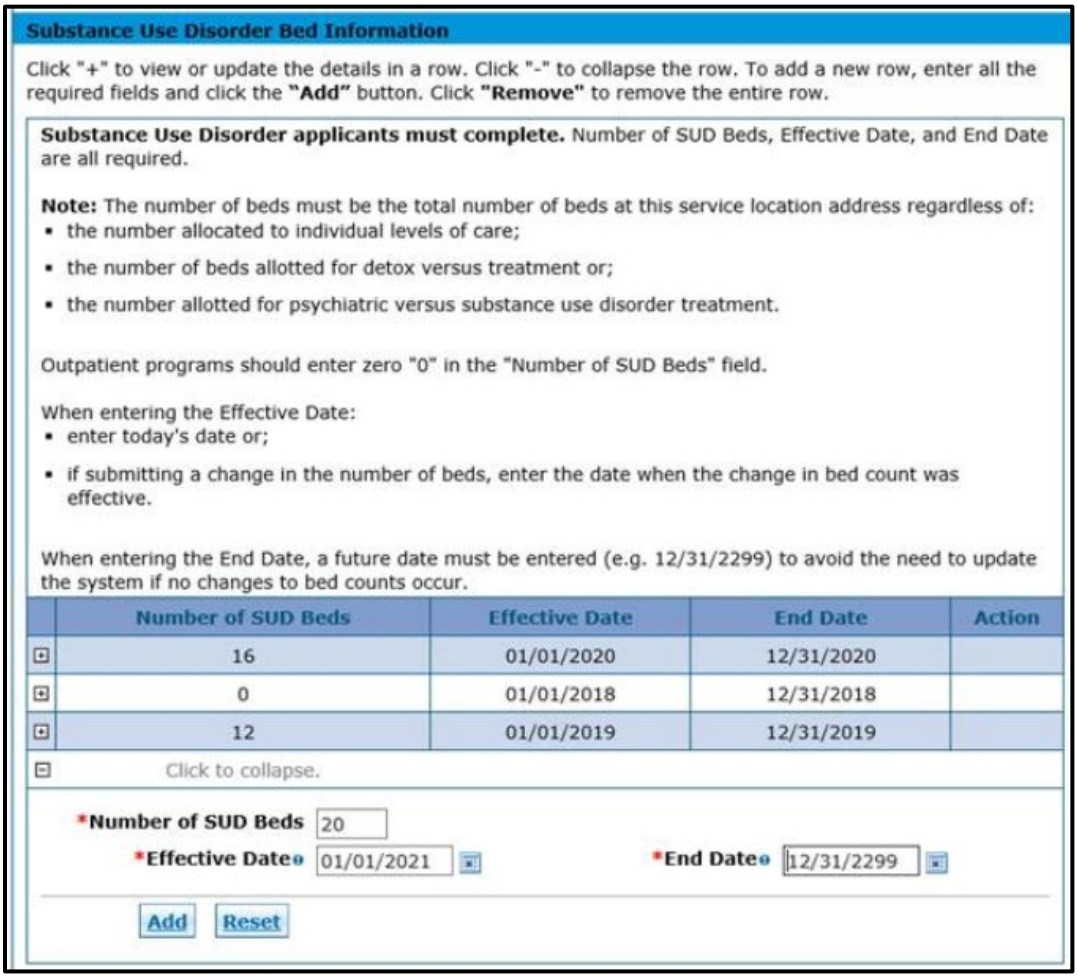


Number of Skilled Beds – Enter the Number of beds in a facility that are certified and/or licensed. This field allows five numeric characters. This field is required.

Effective Date – Enter the Effective date of the hospital bed. Enter eight characters in MM/DD/YYYY format. This field is required.

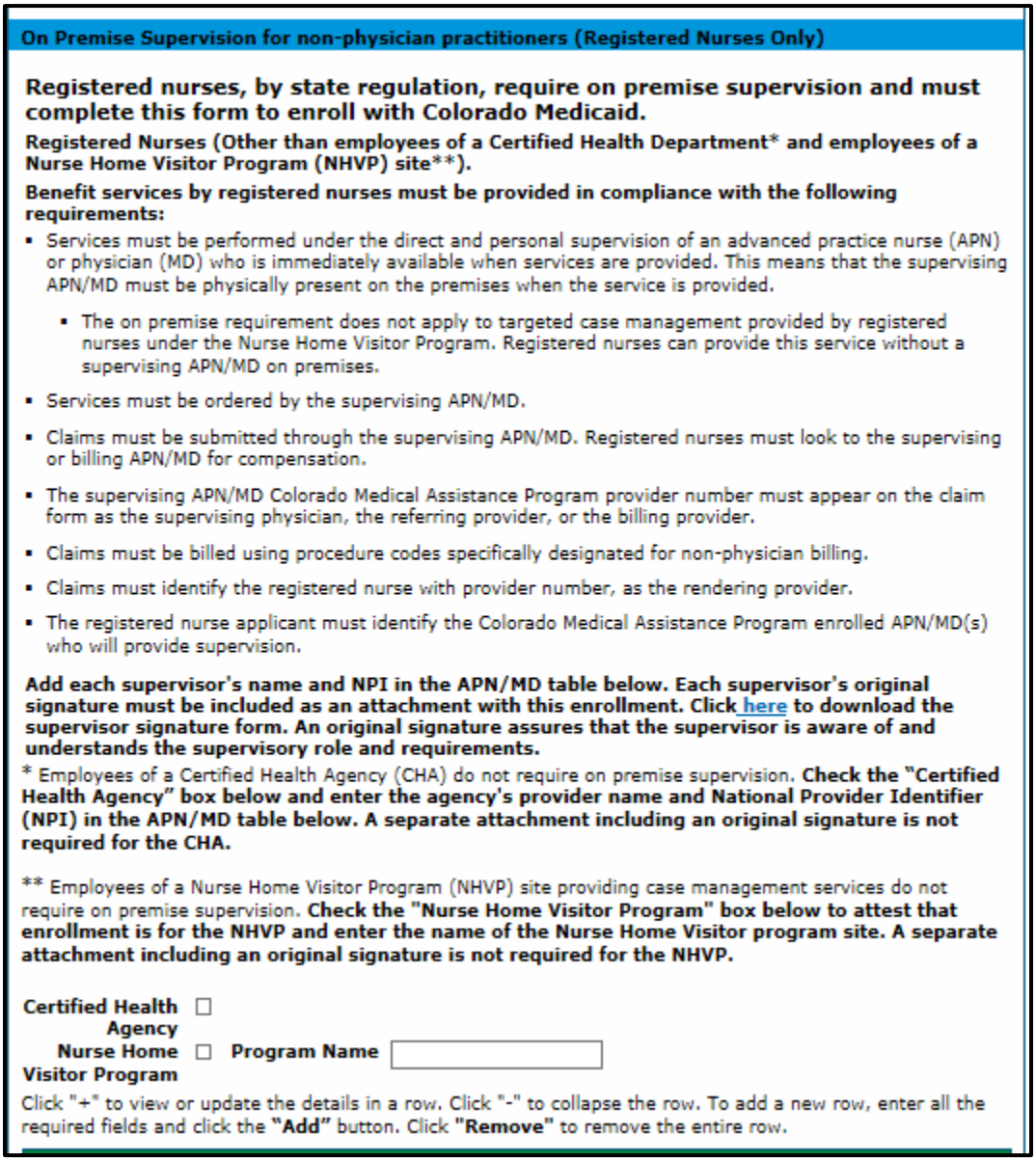
End Date – Enter the End date of the hospital bed. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.

SUD Disorder Facilities



Refer to the Provider Maintenance Provider Web Portal Quick Guide for more information on updating bed counts for Assisted Care Facilities, Hospitals and Substance Use Disorder Facilities.

An individual enrollment with a provider type 24 Non-physician Practitioner Individual (Registered Nurses only) will have the following section on this panel:



On Premise Supervision for non-physician practitioners (Registered Nurses Only)

Registered nurses, by state regulation, require on premise supervision and must complete this form to enroll with Colorado Medicaid.

Registered Nurses (Other than employees of a Certified Health Department* and employees of a Nurse Home Visitor Program (NHVP) site).**

Benefit services by registered nurses must be provided in compliance with the following requirements:

- Services must be performed under the direct and personal supervision of an advanced practice nurse (APN) or physician (MD) who is immediately available when services are provided. This means that the supervising APN/MD must be physically present on the premises when the service is provided.
  - The on premise requirement does not apply to targeted case management provided by registered nurses under the Nurse Home Visitor Program. Registered nurses can provide this service without a supervising APN/MD on premises.
- Services must be ordered by the supervising APN/MD.
- Claims must be submitted through the supervising APN/MD. Registered nurses must look to the supervising or billing APN/MD for compensation.
- The supervising APN/MD Colorado Medical Assistance Program provider number must appear on the claim form as the supervising physician, the referring provider, or the billing provider.
- Claims must be billed using procedure codes specifically designated for non-physician billing.
- Claims must identify the registered nurse with provider number, as the rendering provider.
- The registered nurse applicant must identify the Colorado Medical Assistance Program enrolled APN/MD(s) who will provide supervision.

Add each supervisor's name and NPI in the APN/MD table below. Each supervisor's original signature must be included as an attachment with this enrollment. Click here to download the supervisor signature form. An original signature assures that the supervisor is aware of and understands the supervisory role and requirements.

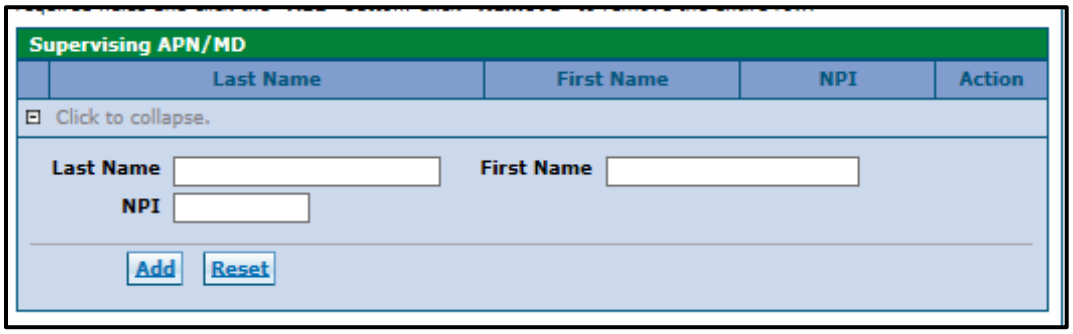
* Employees of a Certified Health Agency (CHA) do not require on premise supervision. **Check the "Certified Health Agency" box below and enter the agency's provider name and National Provider Identifier (NPI) in the APN/MD table below. A separate attachment including an original signature is not required for the CHA.**

** Employees of a Nurse Home Visitor Program (NHVP) site providing case management services do not require on premise supervision. **Check the "Nurse Home Visitor Program" box below to attest that enrollment is for the NHVP and enter the name of the Nurse Home Visitor program site. A separate attachment including an original signature is not required for the NHVP.**

Certified Health Agency ☐

Nurse Home Visitor Program ☐ **Program Name**

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.



Supervising APN/MD

	Last Name	First Name	NPI	Action

⊟ Click to collapse.

Last Name **First Name**

NPI

Add Reset

Registered Nurses are required to complete and attach the RN Supervision Form, found on the Provider Forms web page under the Provider Enrollment & Update Forms drop-down, in addition to completing information on the 'On Premise Supervision for non-physician practitioners' panel in the application.

On-Premises Supervision for Non-Physician Practitioners (Registered Nurses Only) Section

Nursing Home Visitor Program question – This checkbox is used to indicate if the registered nurse is exempt from entering information for the on-premises supervision. Nurses participating only in the Nursing Home Visitor Program are not required to enter a supervising APN/MD. They are required to enter the program site name if the box is checked. This field is required.

Nursing Home Visitor Program Name – Enter the name of the nursing home visitor program the registered nurse is participating in. This field allows up to 50 alphanumeric characters. This field is required.

Supervising APN/MD Section

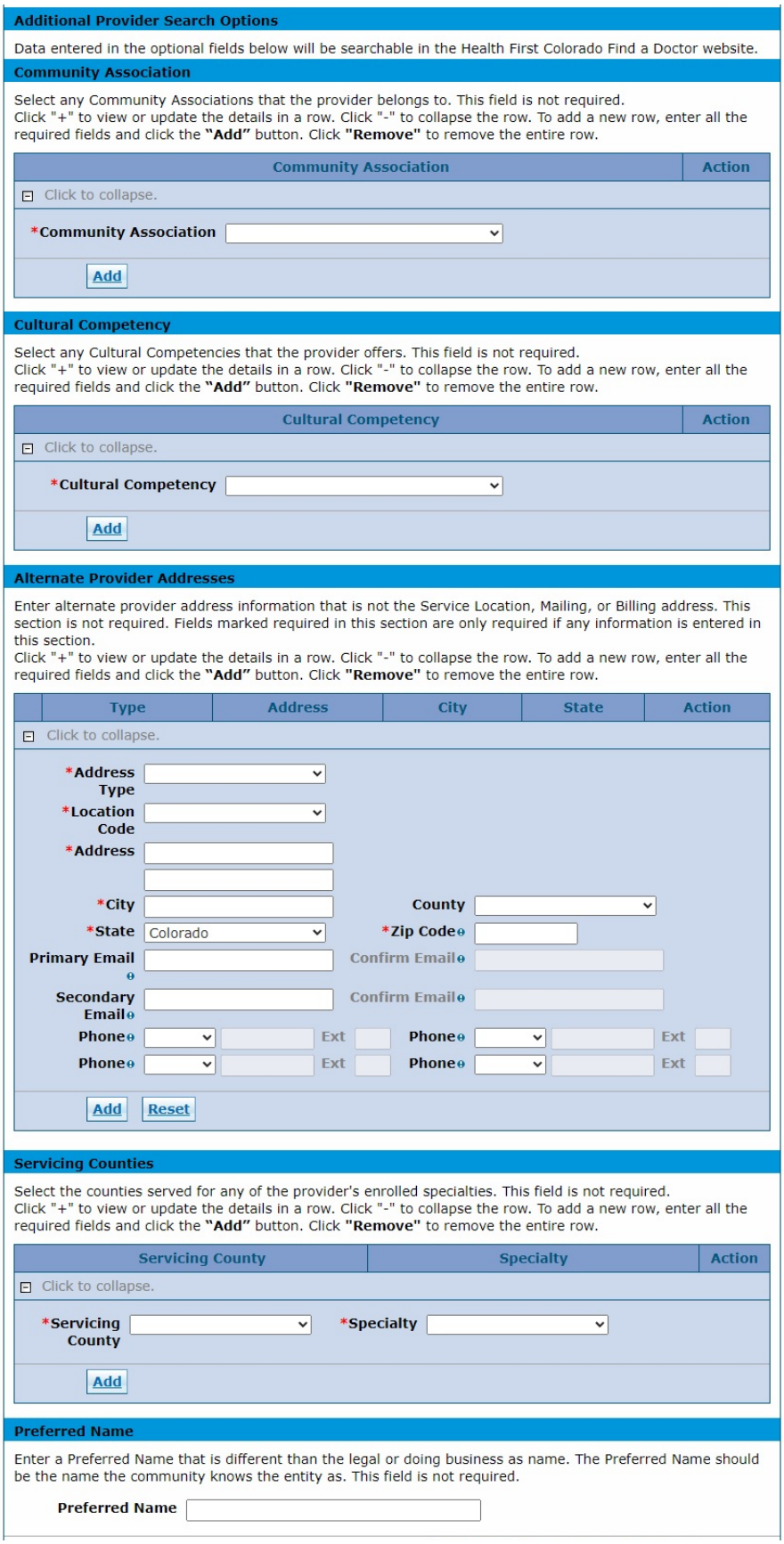
Last Name – Enter the last name of the supervising APN/MD. This field allows up to 60 Alphanumeric characters. This field is required.

First Name – Enter the first name of the supervising APN/MD. This field allows up to 50 alphanumeric characters. This field is required.

NPI – Enter the NPI assigned to the supervising APN/MD. This field allows 15 Alphanumeric characters. This field is required.

Additional Provider Search Options Section

This optional section will present the appropriate subsections based on the Provider Type chosen earlier in the application process. All providers will see the optional subsections of Community Association, Cultural Competency and Preferred Name. Select providers will see additional subsections of Alternate Provider Addresses and Servicing Counties.



Additional Provider Search Options

Data entered in the optional fields below will be searchable in the Health First Colorado Find a Doctor website.

Community Association

Select any Community Associations that the provider belongs to. This field is not required.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Community Association	Action

Click to collapse.

*Community Association

Add

Cultural Competency

Select any Cultural Competencies that the provider offers. This field is not required.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Cultural Competency	Action

Click to collapse.

*Cultural Competency

Add

Alternate Provider Addresses

Enter alternate provider address information that is not the Service Location, Mailing, or Billing address. This section is not required. Fields marked required in this section are only required if any information is entered in this section.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Type	Address	City	State	Action

Click to collapse.

*Address Type

*Location Code

*Address

*City

County

*State Colorado

*Zip Code

Primary Email

Confirm Email

Secondary Email

Confirm Email

Phone Ext Phone Ext

Phone Ext Phone Ext

Add Reset

Servicing Counties

Select the counties served for any of the provider's enrolled specialties. This field is not required.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Servicing County	Specialty	Action

Click to collapse.

*Servicing County

*Specialty

Add

Preferred Name

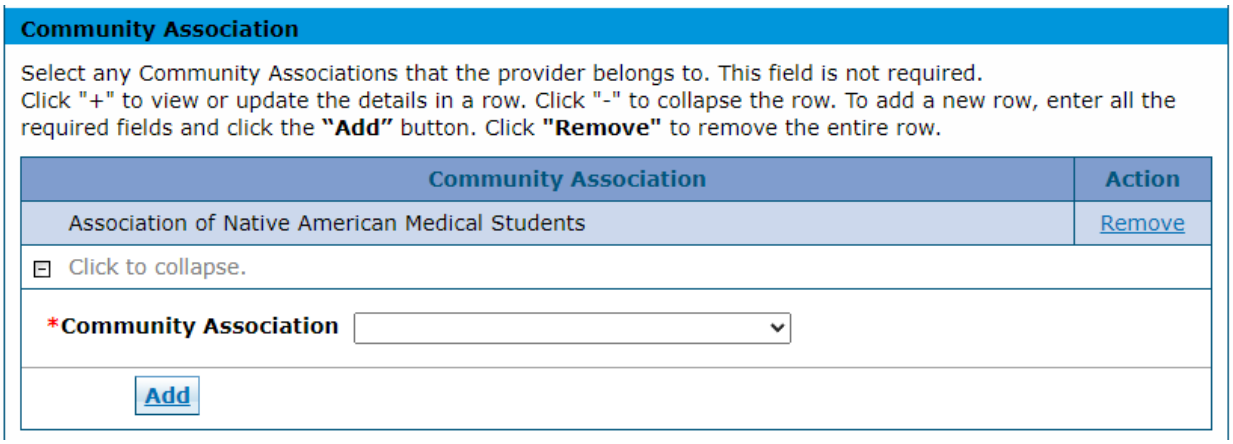
Enter a Preferred Name that is different than the legal or doing business as name. The Preferred Name should be the name the community knows the entity as. This field is not required.

Preferred Name

Community Association

All providers may identify specific community association(s) and add as many as needed. This information will be searchable on the Health First Colorado Find a Doctor web page.

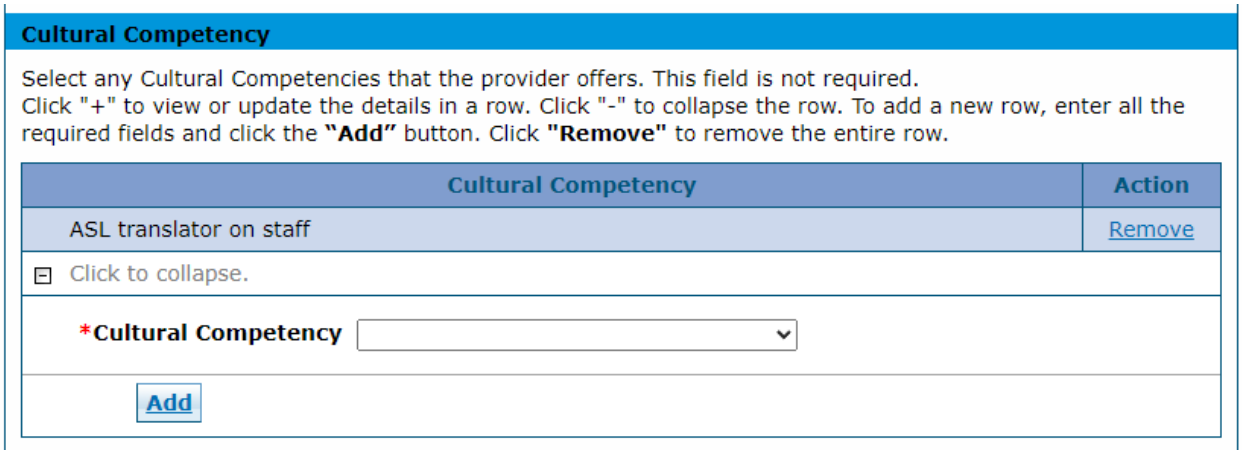
After each Community Association is selected, click the “Add” button. The screen will update and add the selected item. If a record needs to be removed, click the “Remove” link. Add as many Community Association records as needed.



Cultural Competency

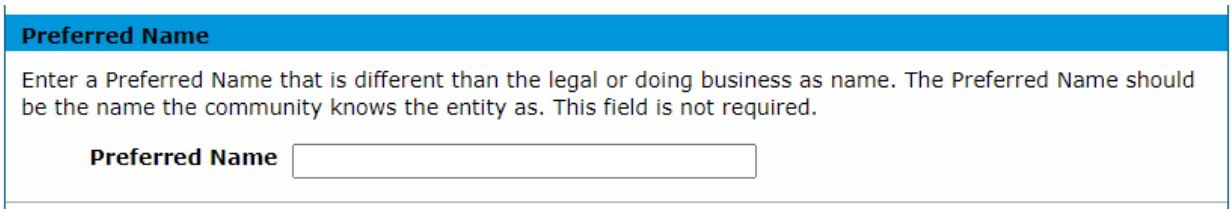
All providers may identify specific cultural competencies and add as many as needed. This information will be searchable on the Health First Colorado Find a Doctor web page.

After each Cultural Competency is selected, click the “Add” button. The screen will update and add the selected item. If a record needs to be removed, click the “Remove” link. Add as many Cultural Competency records as needed.



Preferred Name

All providers may specify a Preferred Name that is different than the legal name or doing-business-as name. The Preferred Name should be the name for which the community knows the entity. This information will be searchable on the Health First Colorado Find a Doctor web page.

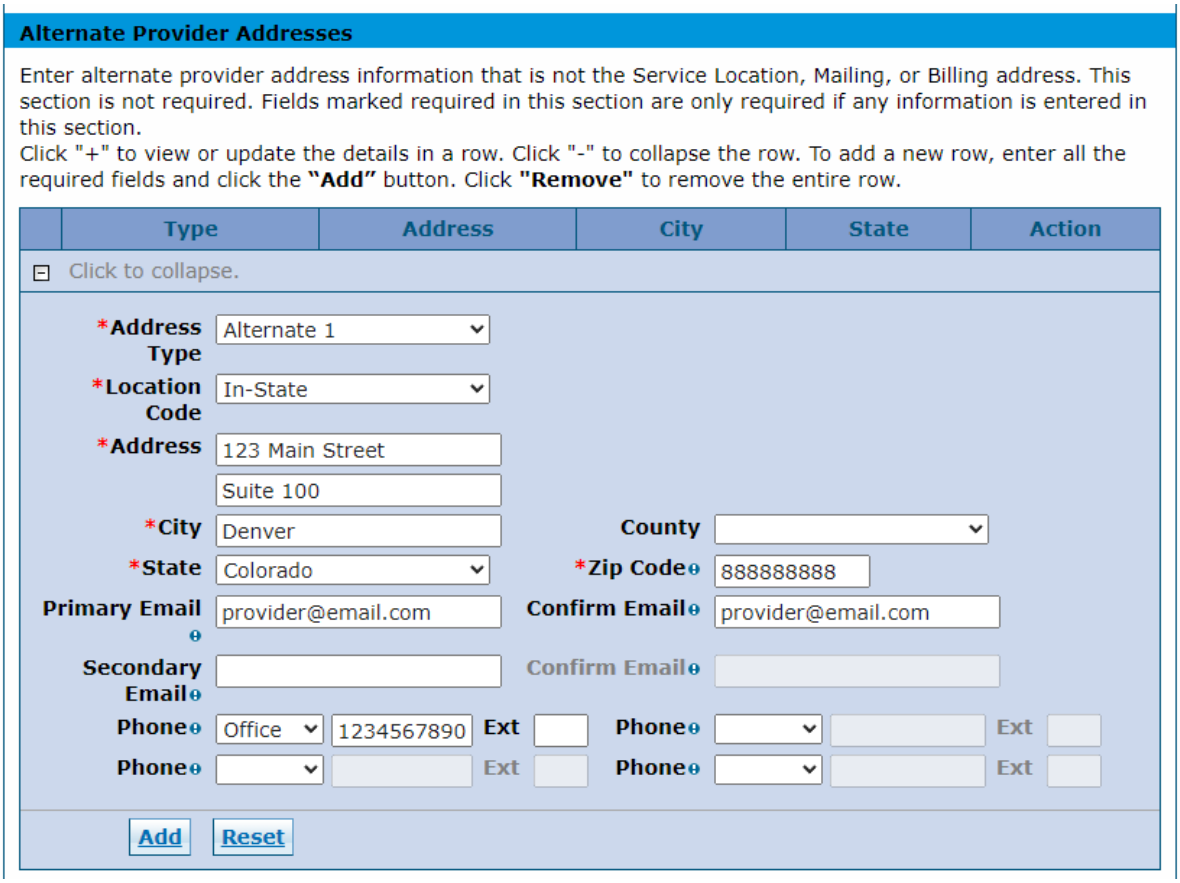


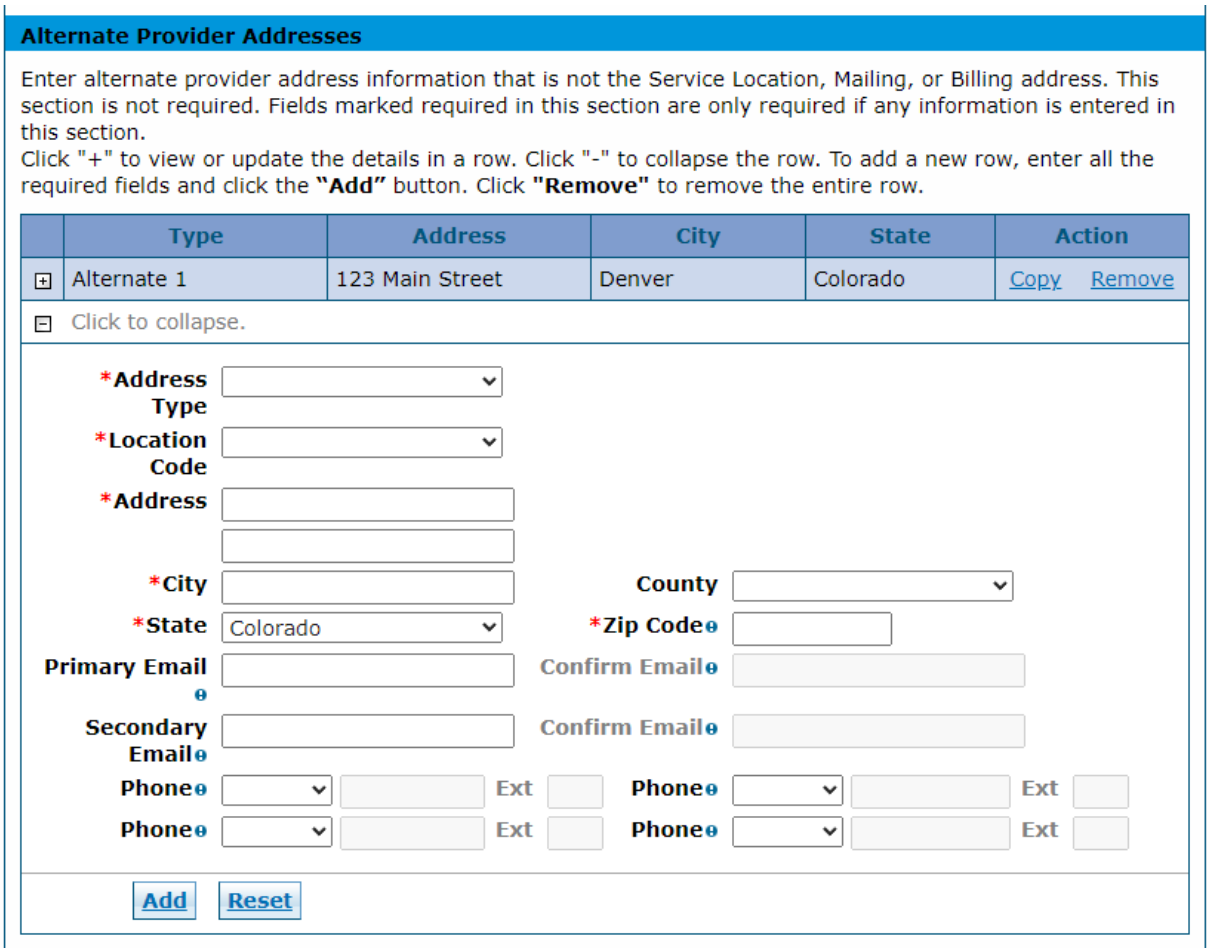
Alternate Provider Addresses

Select providers may enter up to three (3) alternate addresses. These addresses should be different than the Service Location, Mailing and Billing addresses entered on the Addresses panel. This information will be searchable on the Health First Colorado Find a Doctor web page.

After each address record is populated, click the "Add" button. The screen will update and add the address. If a record needs to be removed, click the "Remove" link. Up to three addresses can be added.

Complete address information, a Primary Email and an Office Phone must be entered to add an address.

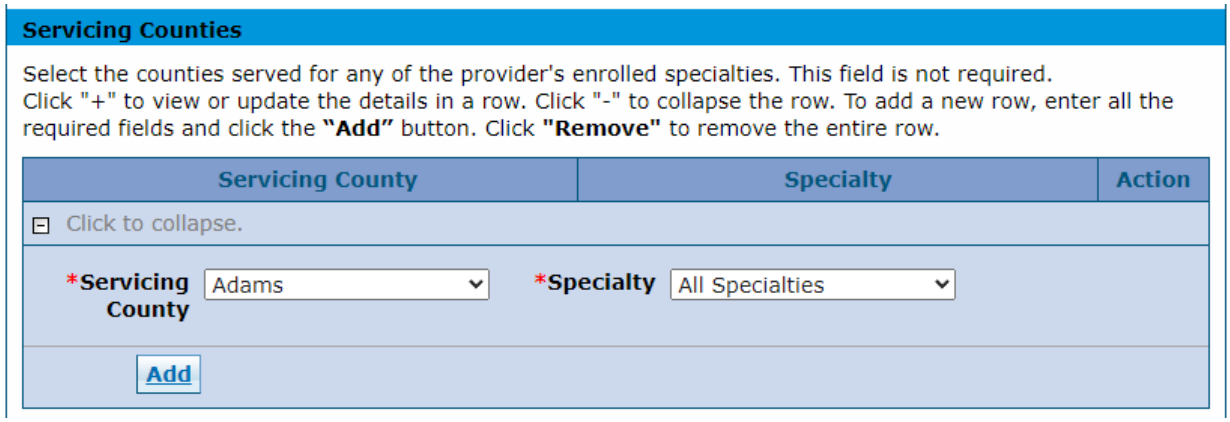


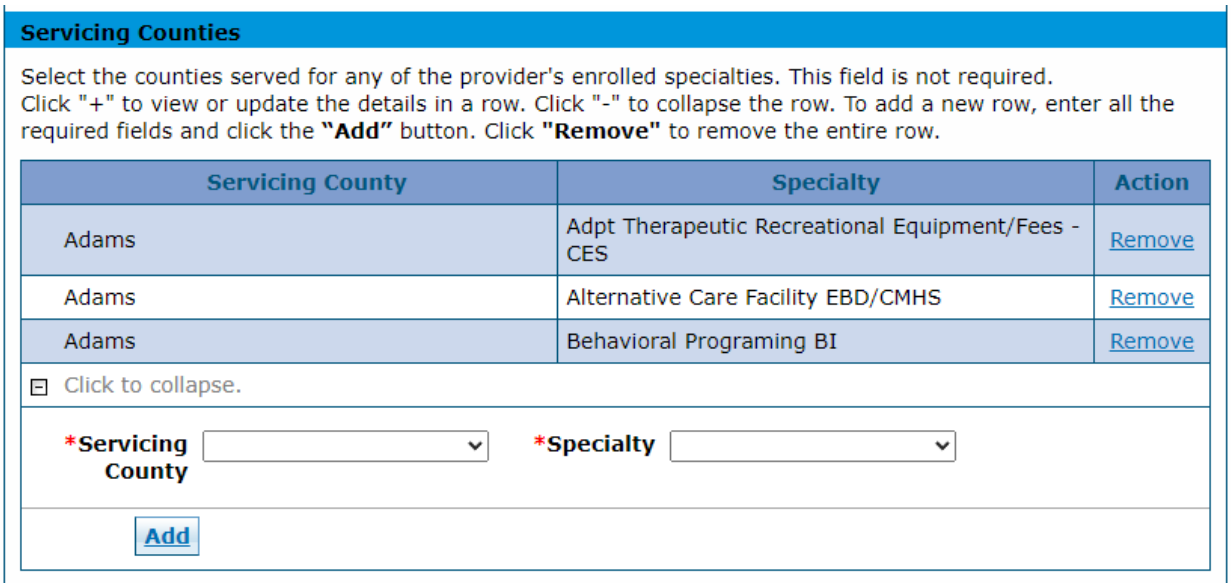


Servicing Counties

Select providers may identify the specific counties served for any of the enrolling specialties. If the provider has more than one specialty, "All Specialties" can be selected in the Specialty drop-down list and a record will be added for each specialty and selected Servicing County. This information will be searchable on the Health First Colorado Find a Doctor web page.

After each record is populated, click the "Add" button. The screen will update and add the record. If a record needs to be removed, click the "Remove" link. Duplicate records are not allowed.

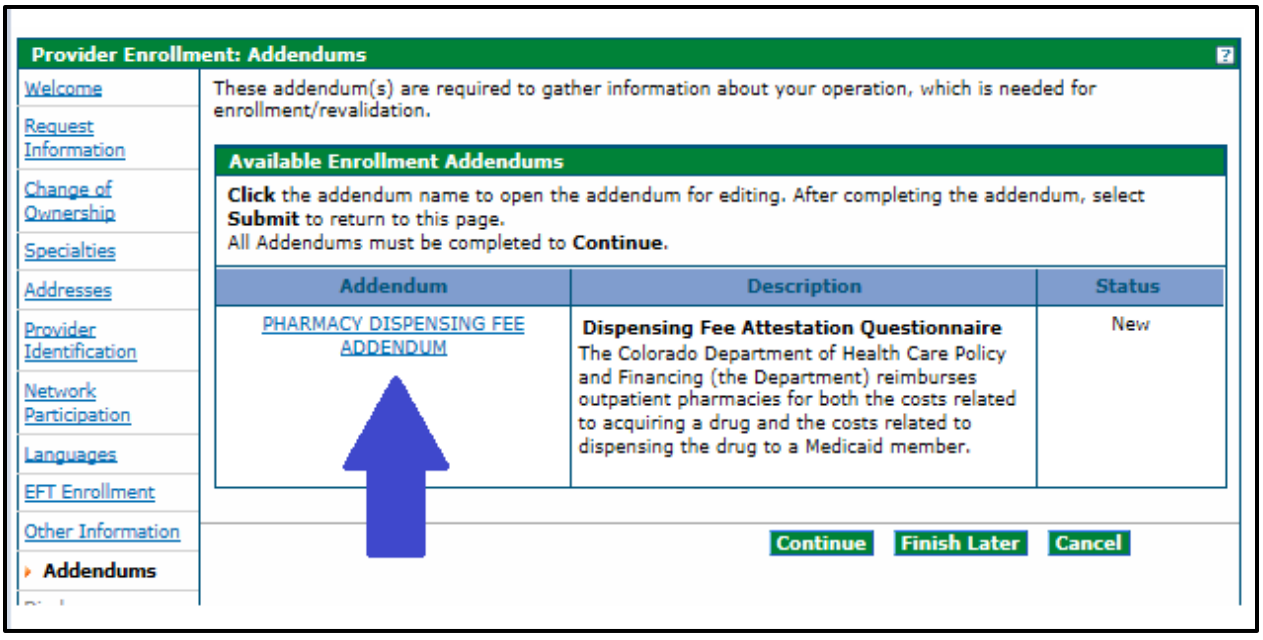




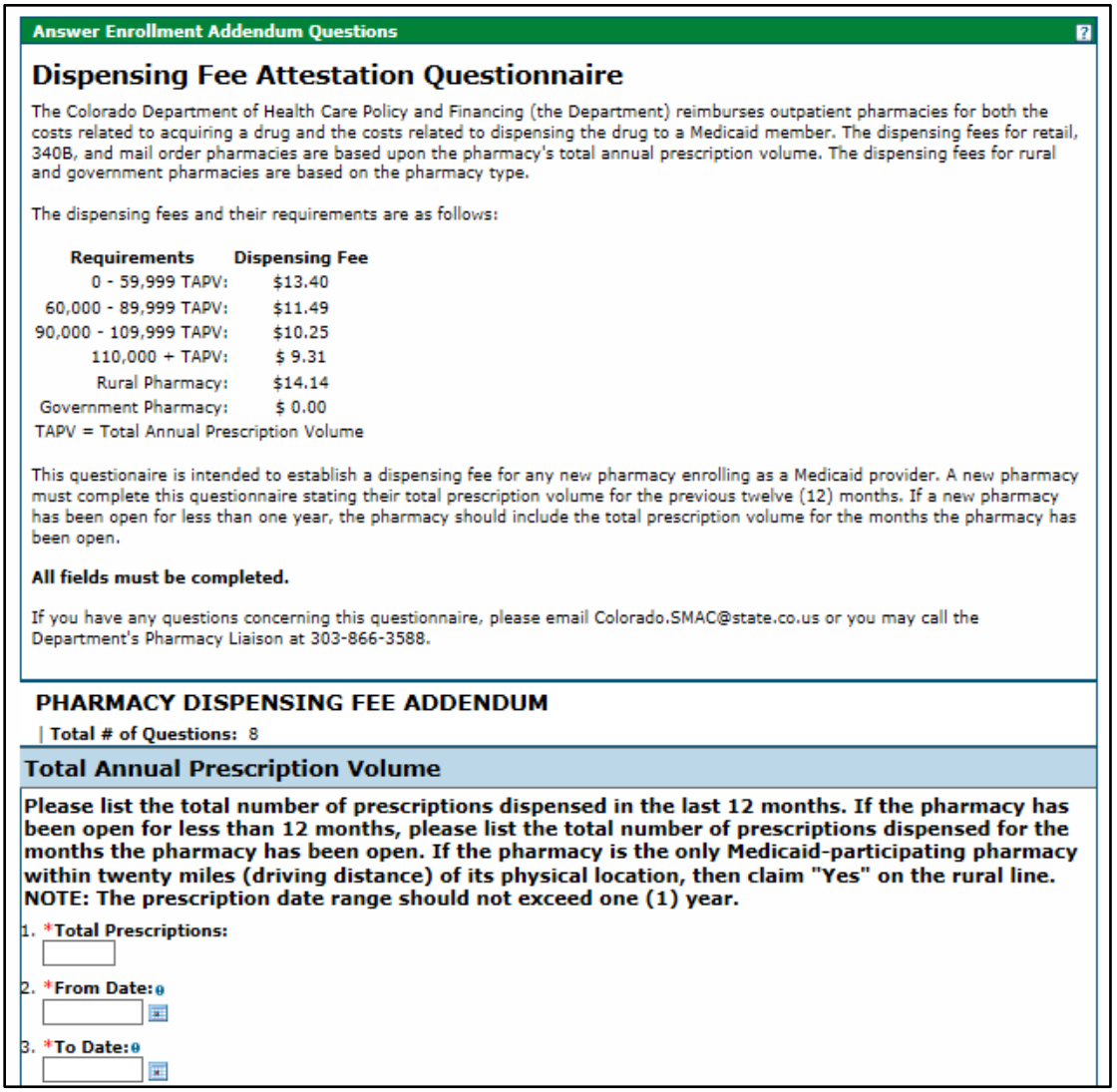
Addendums Panel

Note: The Addendums panel will not display for PACE-Only Subcontractor provider enrollment types.

This is an example of an Addendums panel. **Only when enrolling as a pharmacy will there be anything to complete here. Select the link to complete the Dispensing Fee Attestation Questionnaire.**



Answer Enrollment Addendum Questions Section (Pharmacy Only)

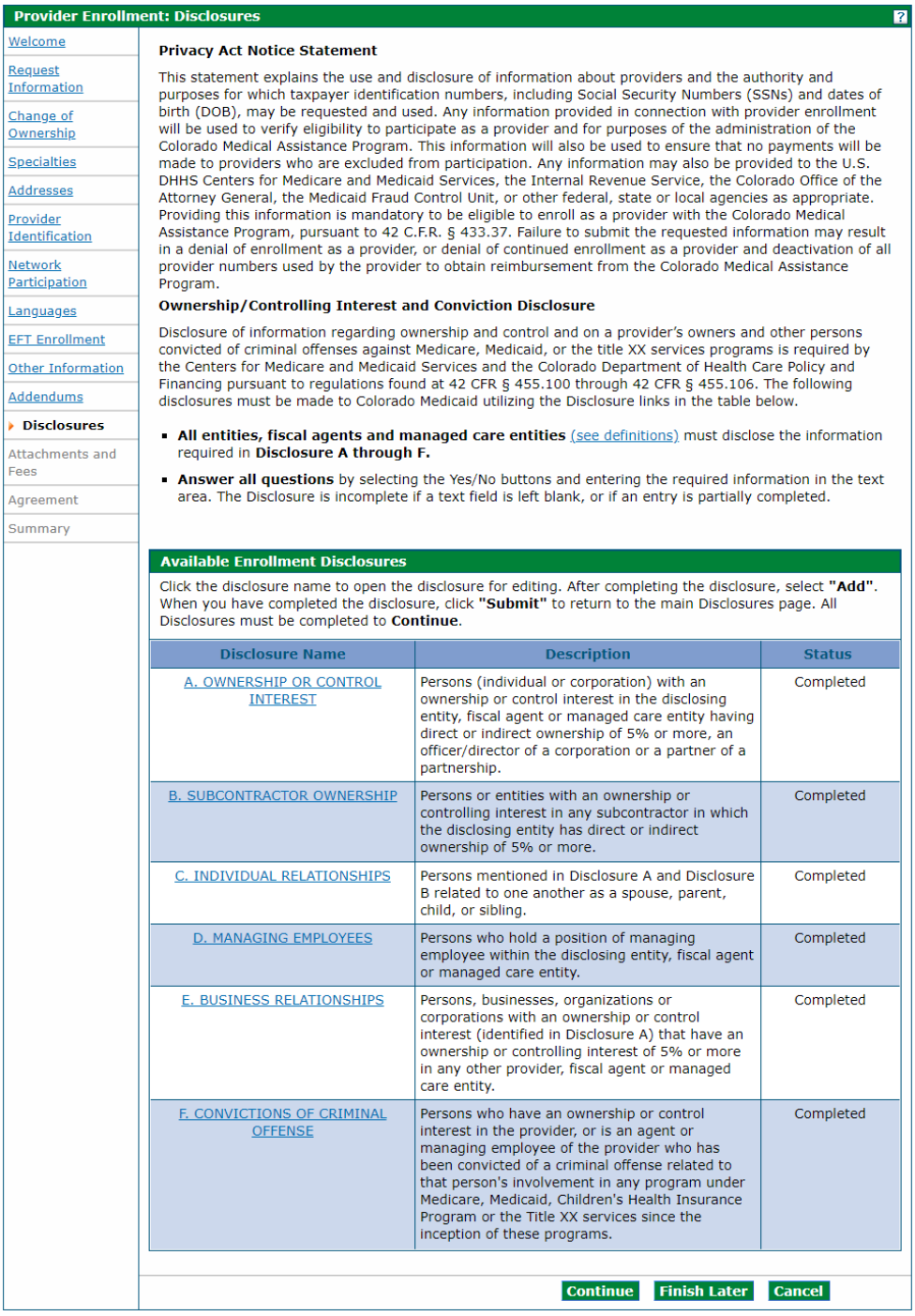


Disclosures Panel

Note: The Disclosures panel will not display for PACE-Only Subcontractor provider enrollment types.

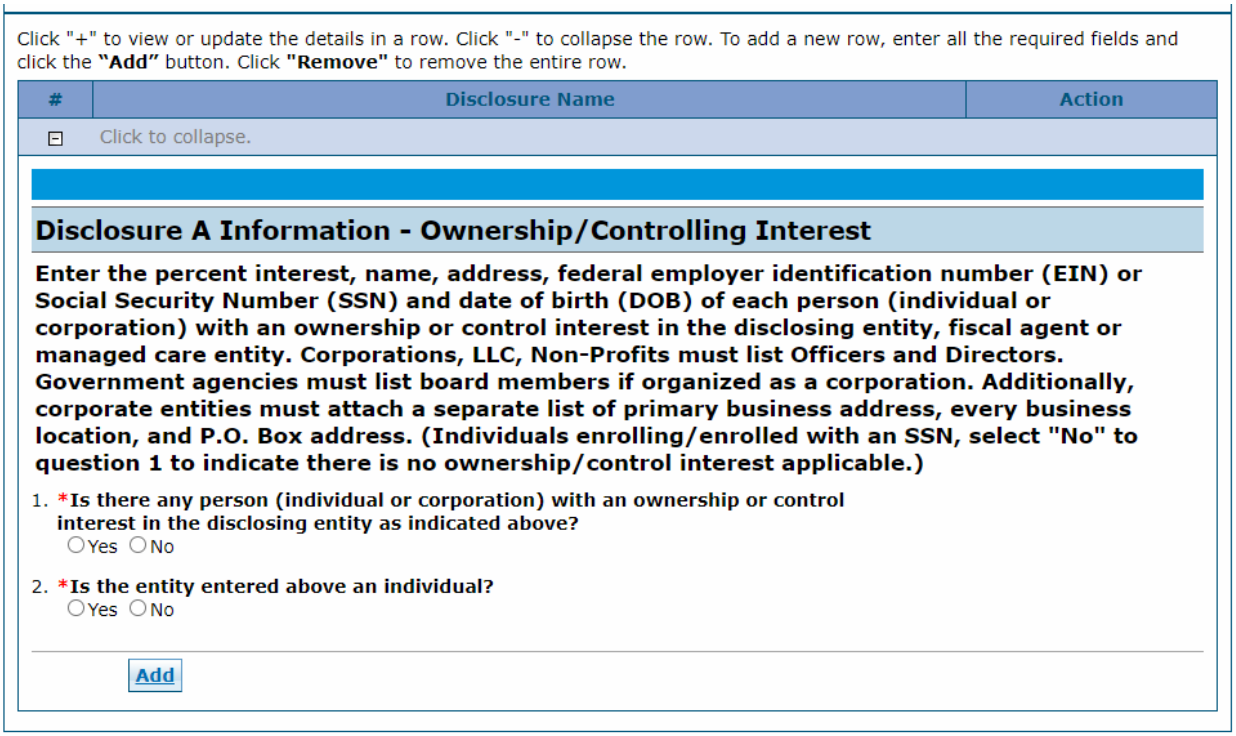
Disclosures are required for every enrollment and involve information regarding ownership/control interest, relationships, criminal convictions, etc. Select each Disclosure link and answer all questions contained within the disclosure.

The Disclosures indicate a “New” status on the right-hand side of the panel until each is complete. All Disclosures must be completed to proceed with the enrollment.

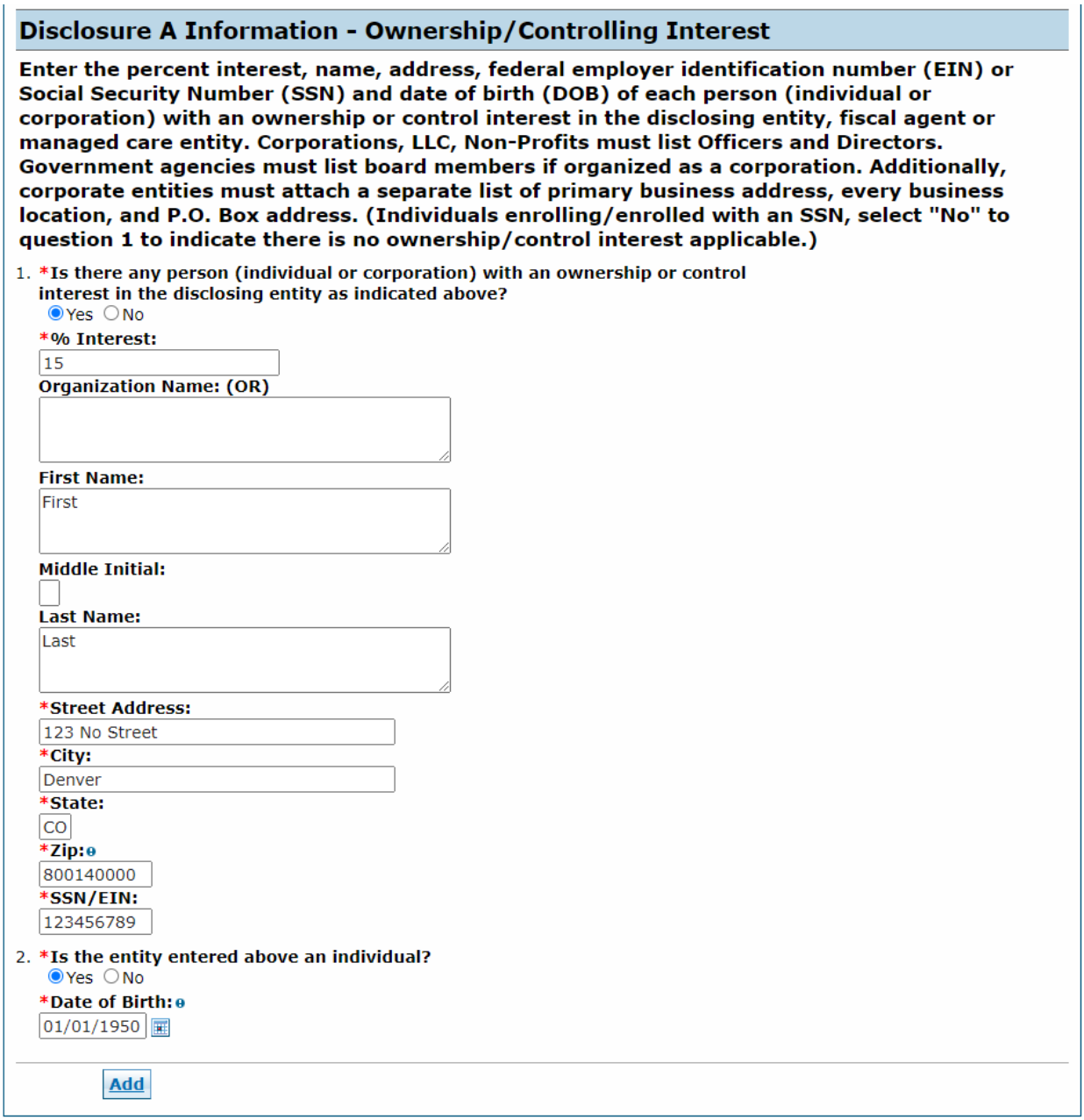


Disclosure A is regarding ownership and controlling interest for the applicant. Indicate the information for each person (individual or corporation) with an ownership or controlling interest for the applicant. For individual applicants (SSN enrollments) it is recommended to select the 'No' option in the first question to indicate that ownership/control interest does not apply to the individual.

Disclosures Panel – Ownership/Controlling Interest Disclosure A



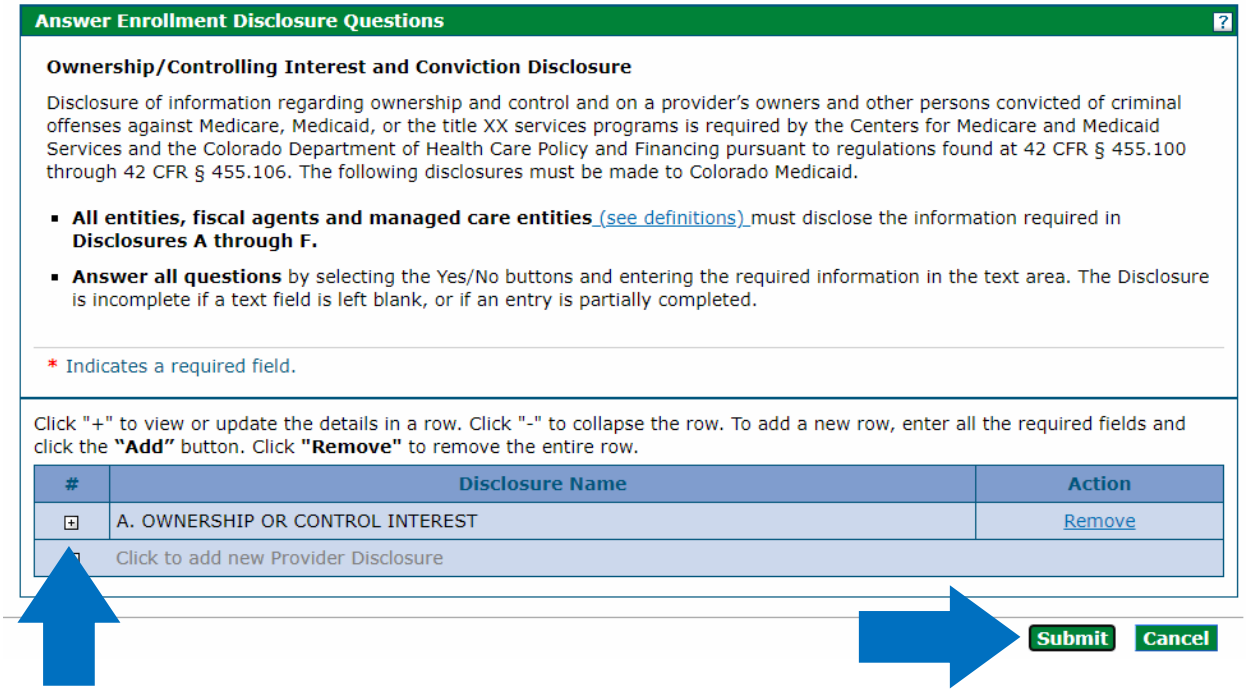
A "Yes" answer will open an additional section as shown below, for the required information to be entered.



If the entity is an individual owner, then they must select 'Yes' to question 2 and enter the individual's date of birth, as shown above. If the user selects that the entity is not an individual, but enters information for an individual, the application will be returned to the user to correct the information.

When this information is complete, click the "**Add**" button and the panel will update as shown below.

Disclosures Panel – Ownership/Controlling Interest Disclosure A – Add or Submit



Continue to add entities as applicable. For additional entries click the "**+**" symbol on the left-hand side of the panel.

When all Ownership/Controlling Interest is entered, click the "**Submit**" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed", as shown below.

Disclosures Panel – Ownership/Controlling Interest Disclosure A – Completed

Available Enrollment Disclosures

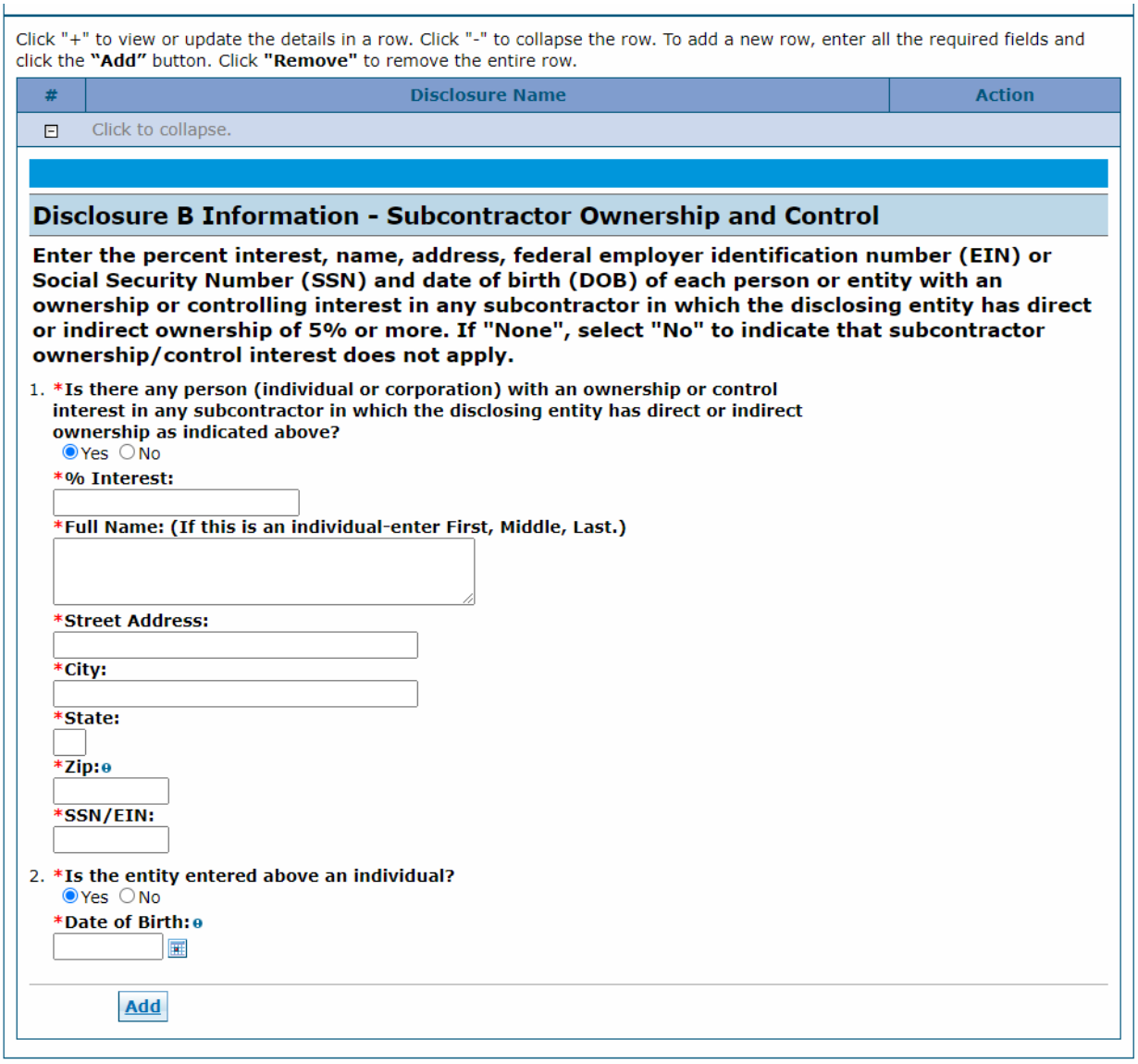
Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

Disclosure Name	Description	Status
A. OWNERSHIP OR CONTROL INTEREST	Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more, an officer/director of a corporation or a partner of a partnership.	Completed
B. SUBCONTRACTOR OWNERSHIP	Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.	New
C. INDIVIDUAL RELATIONSHIPS	Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.	New
D. MANAGING EMPLOYEES	Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.	New
E. BUSINESS RELATIONSHIPS	Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.	New
F. CONVICTIONS OF CRIMINAL OFFENSE	Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.	New

Disclosure B is regarding Subcontractor Ownership and Control. Indicate all persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity/applicant has direct or indirect ownership of 5% or more.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “**Add**” button and the panel will update.

Disclosures Panel – Subcontractor Ownership and Control Disclosure B - Questions

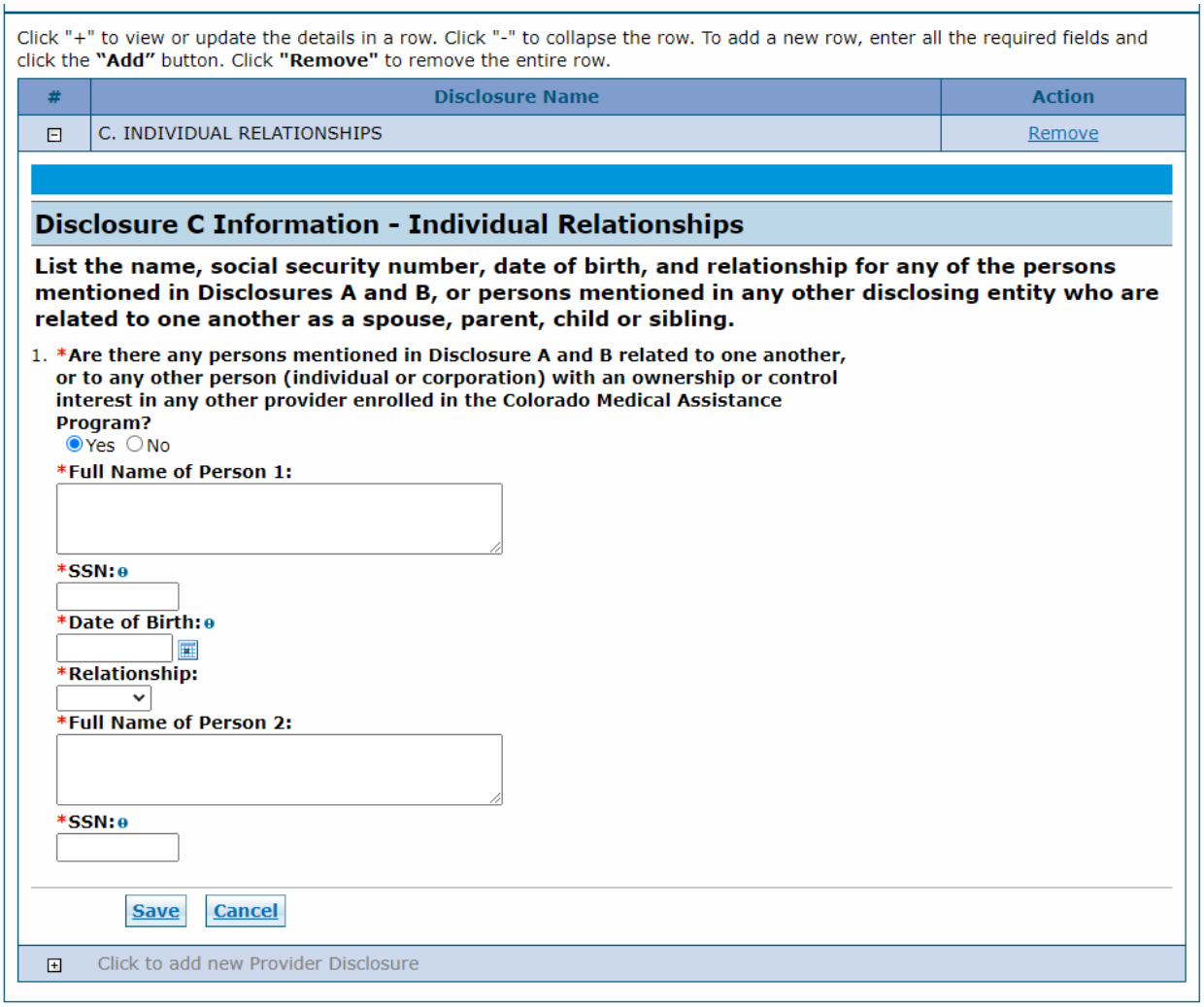


Continue to add entities as applicable. When all Subcontractor Ownership and Control information is entered, click the “**Submit**” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

Disclosure C is regarding Individual Relationships. Indicate any individuals mentioned in Disclosure A and Disclosure B that are related to one another as a spouse, parent, child or sibling.

A “Yes” answer will open an additional section for the required information to be entered.

Disclosures Panel – Individual Relationships Disclosure C – Questions



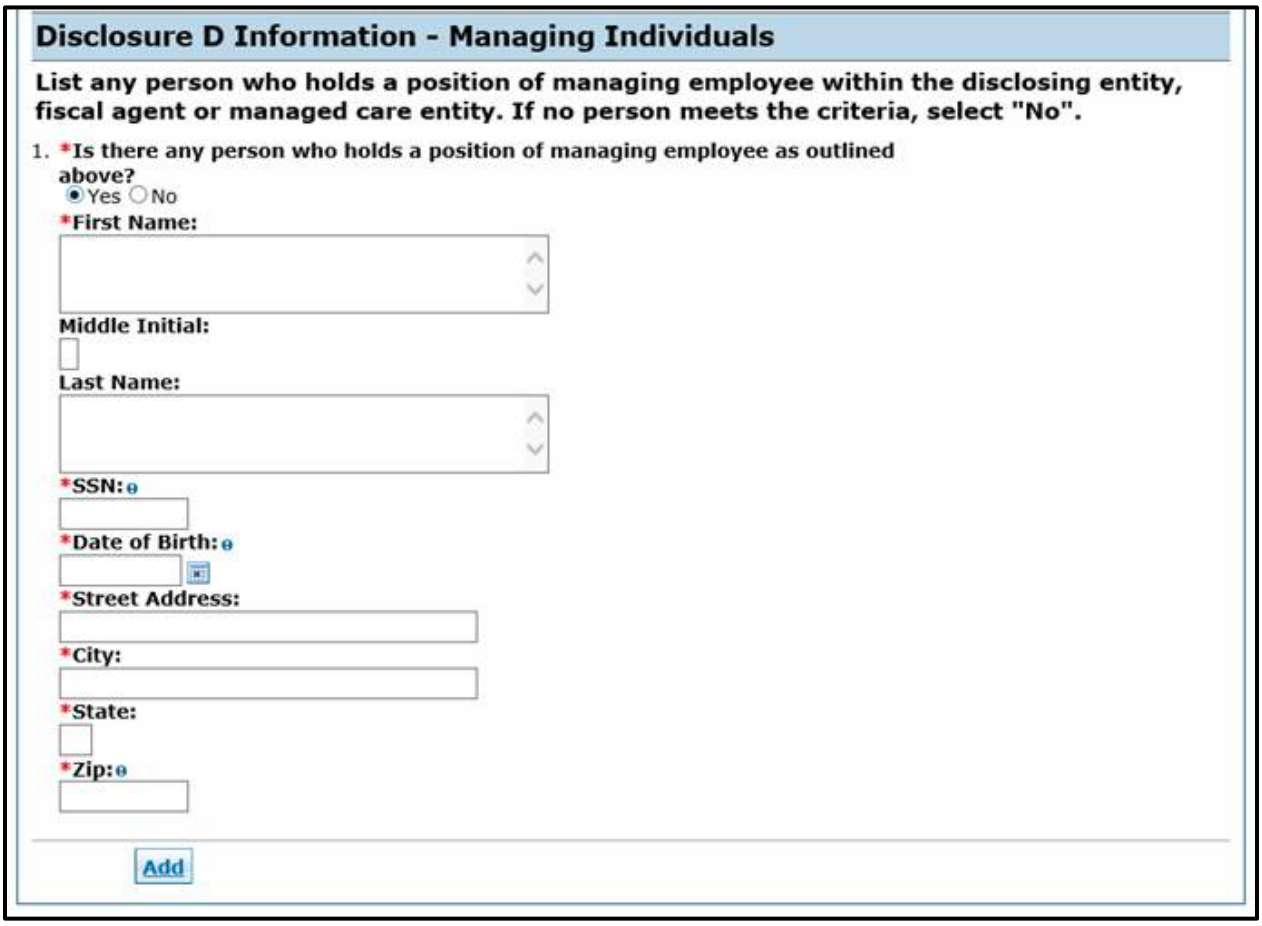
When the information is completed, click the “**Add**” button and the panel will update.

Continue to add individuals as applicable. When all Individual Relationships are entered, click the “**Submit**” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

Disclosure D is regarding Managing Individuals. Indicate any individuals that hold a position of managing employee within the disclosing entity/applicant.

A "**Yes**" answer will open an additional section for the required information to be entered. When the information is completed, click the "**Add**" button and the panel will update.

Disclosures Panel – Managing Individuals Disclosure D – Questions

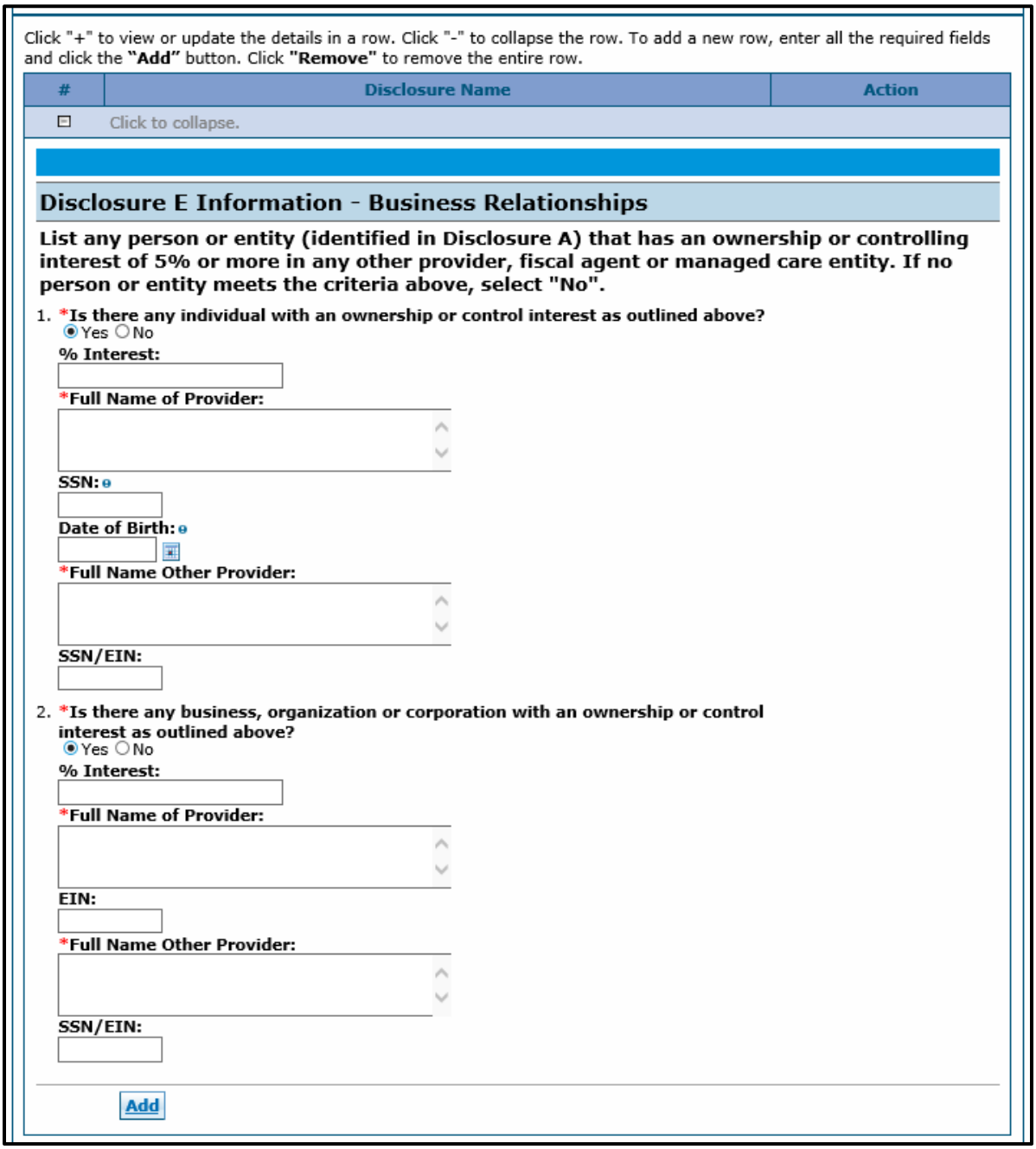


Continue to add individuals as applicable. When all Managing Individuals are entered, click the "**Submit**" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed".

Disclosure E is regarding Business Relationships. Indicate any persons or entity (identified in Disclosure A) that has an ownership or controlling interest of 5% or greater in any other provider, fiscal agent or managed care entity.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “**Add**” button and the panel will update.

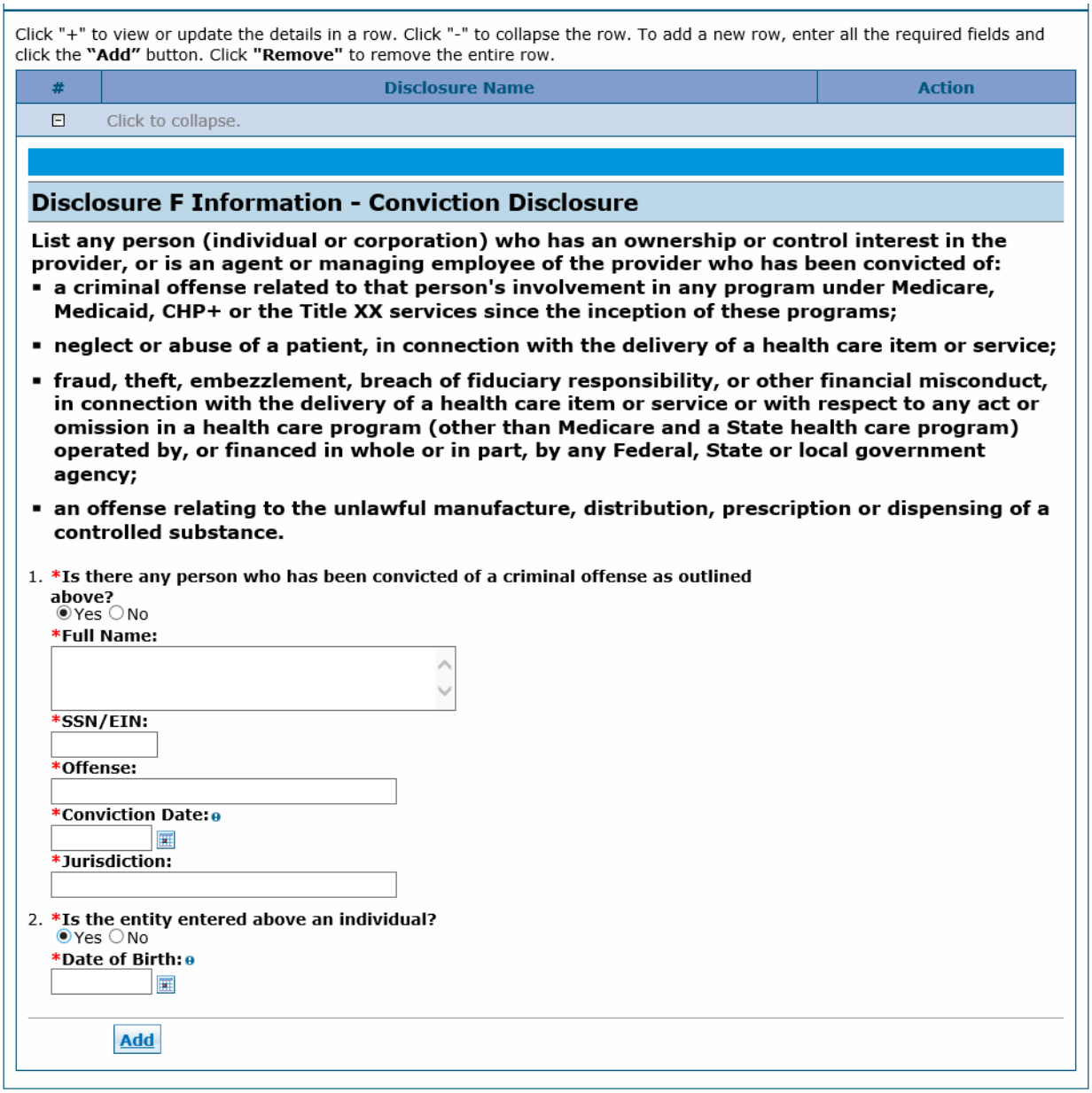
Disclosures Panel – Business Relationships Disclosure E– Questions



Continue to add entities as applicable. When all Business Relationships are entered, click the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

Disclosure F is regarding Convictions. Indicate any persons with ownership or controlling interest in, or that is an agent or managing employee of the applicant who has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.

Disclosures Panel – Conviction Disclosure F – Questions



A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “**Add**” button and the panel will update.

Continue to add entities as applicable. When all Convictions are entered, click the “**Submit**” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

When all questions have been completed within the Disclosures panel, select “**Continue**”, “**Finish Later**”, or “**Cancel**”.

Disclosures Panel – Completed

Available Enrollment Disclosures

Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

Disclosure Name	Description	Status
A. OWNERSHIP OR CONTROL INTEREST	Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more, an officer/director of a corporation or a partner of a partnership.	Completed
B. SUBCONTRACTOR OWNERSHIP	Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.	Completed
C. INDIVIDUAL RELATIONSHIPS	Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.	Completed
D. MANAGING EMPLOYEES	Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.	Completed
E. BUSINESS RELATIONSHIPS	Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.	Completed
F. CONVICTIONS OF CRIMINAL OFFENSE	Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.	Completed

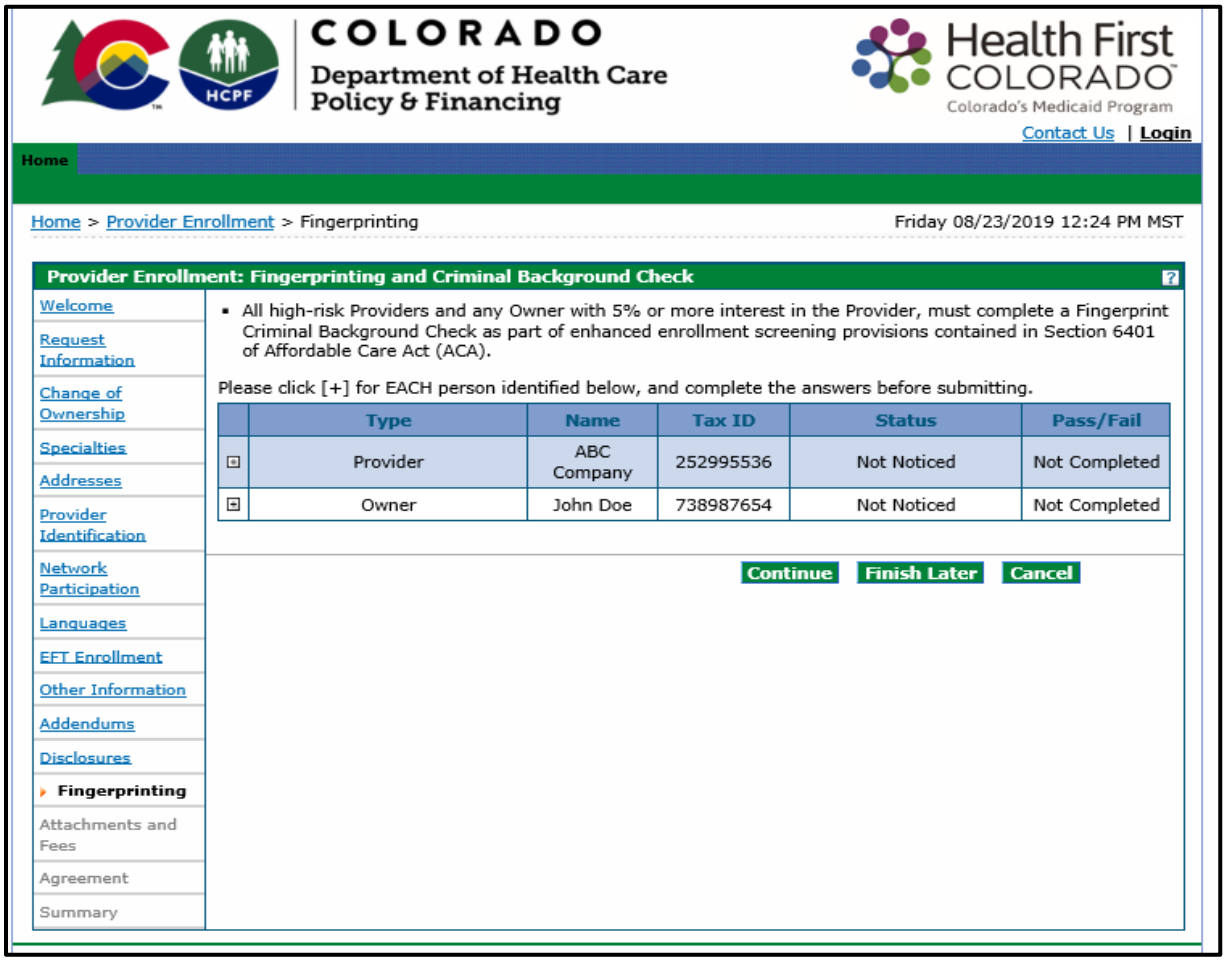
Continue Finish Later Cancel

Fingerprinting

Note: The Fingerprinting panel will not display for PACE-Only Subcontractor provider enrollment types.

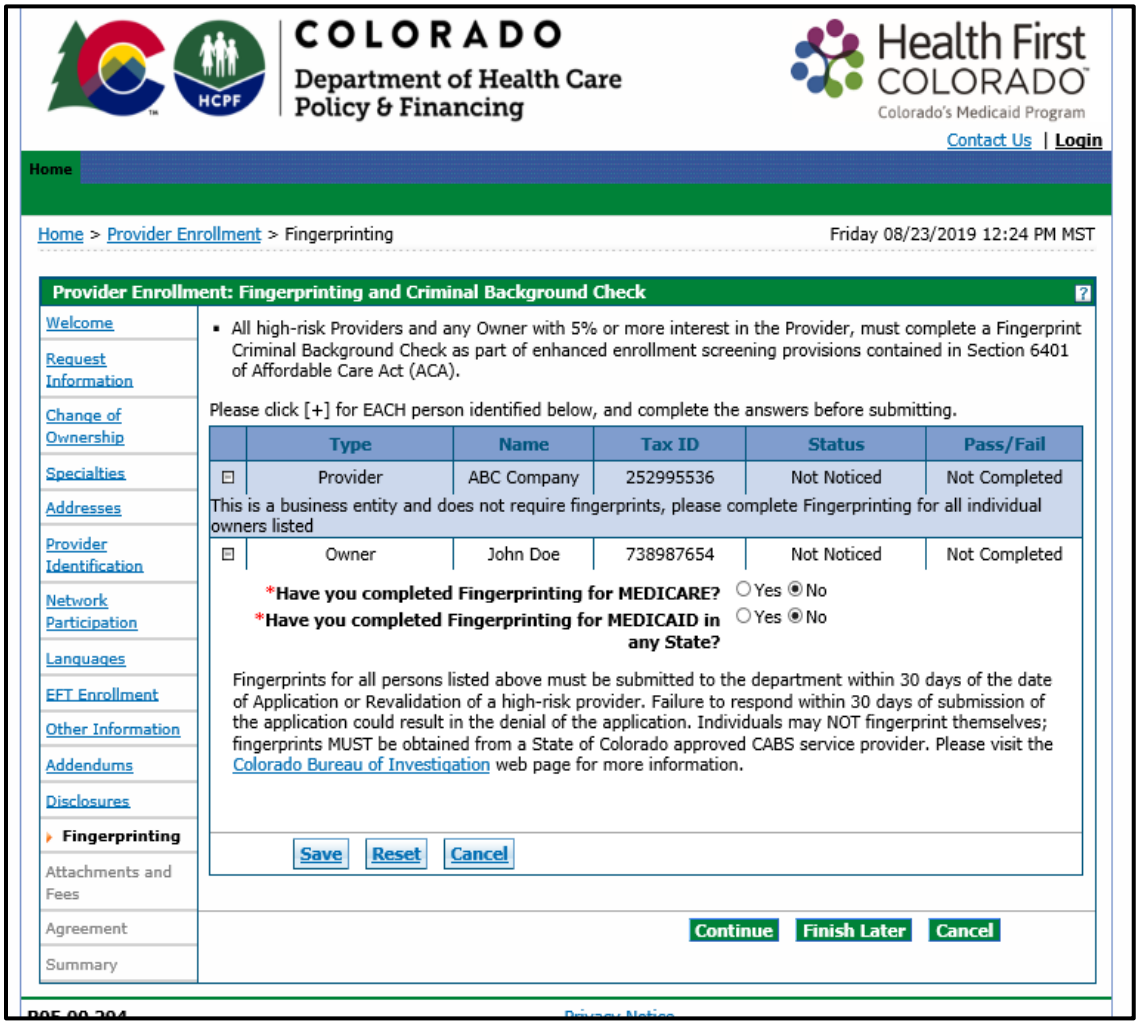
If the enrolling provider is determined to be a **high-risk provider type**, as determined by CMS or the Department, they will be presented with, and required to complete, the **Fingerprinting panel**. This Provider's data is pulled from the Provider Identification panel and the Request Information panel in the application. Owner information will be populated by the individual owner information that is entered on the Disclosures panel in the application. For providers that are business entities, all owners with 5% or more interest in the business will be displayed with a status indicating any individuals that need to submit fingerprints at this time. Visit the Information by Provider Type web page to view the risk level.

Fingerprinting Panel – Fingerprinting and Criminal Background Check



Click the "**+**" next to any Owner(s) that needs to complete fingerprinting. Then answer the questions presented within the panel.

Fingerprinting Panel – Fingerprinting and Criminal Background Check – Marked No

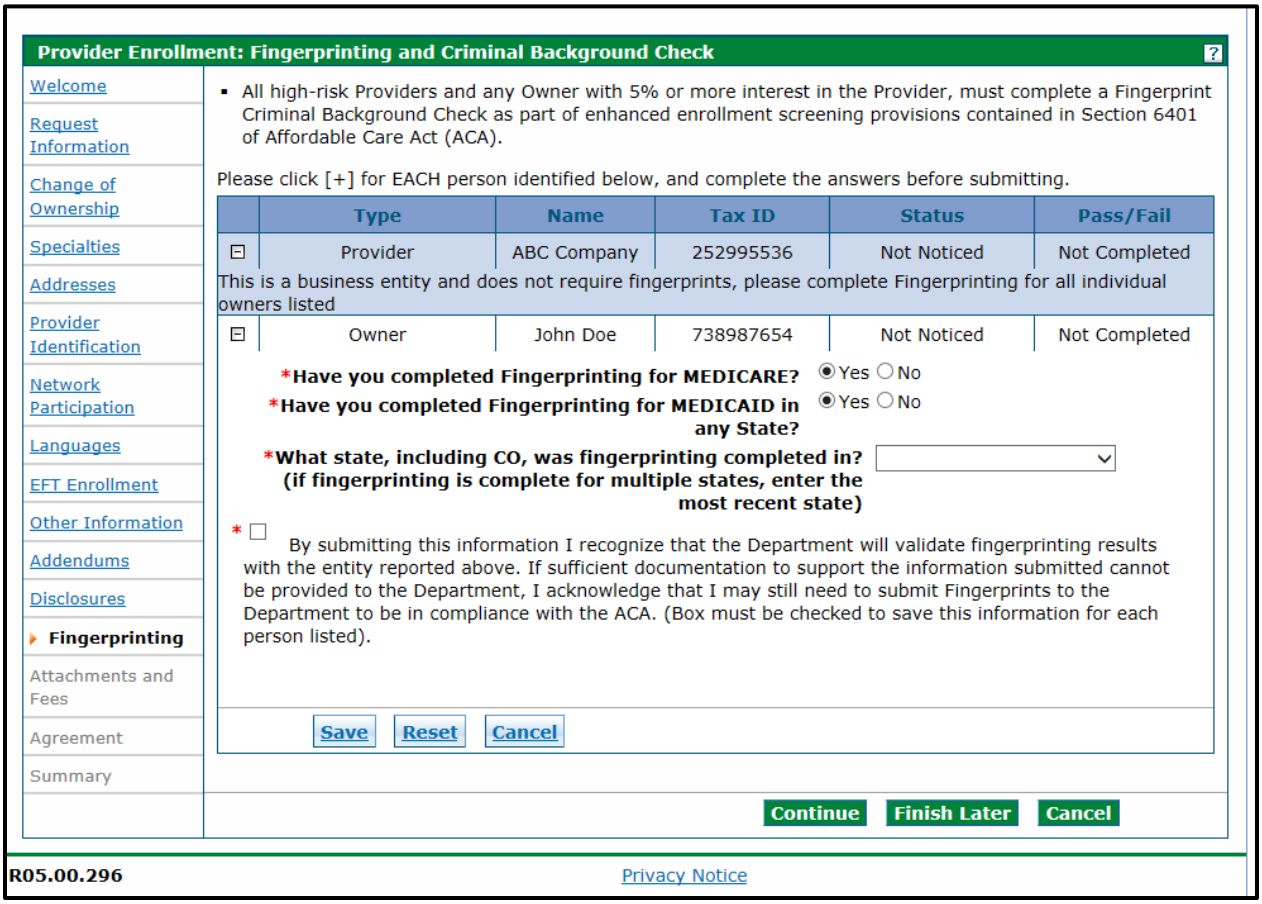


If an Owner has **not** completed their Fingerprinting Background Check (**for either *Medicare* or *Medicaid***), follow the instructions on this panel to have fingerprints submitted within **30 calendar days** of the submission of the enrollment application.

Refer to the Fingerprinting FAQ on the Provider FAQ Central web page and select Fingerprinting from the drop-down.

If an Owner has completed the Fingerprinting Background Check (**for either *Medicare* or *Medicaid***), mark "Yes" next to the appropriate selection. If marked "Yes", the panel will update and request confirmation of which state the fingerprinting was completed in. Then check the box next to the acknowledgement statement.

Fingerprinting Panel – Fingerprinting and Criminal Background Check – Marked Yes



Click "**Save**" once completed for **each Owner** and then click "**Continue**" to the next section.

Once the application is submitted, Providers and owners requiring fingerprinting will be given specific instructions on how to proceed.

Attachments and Fees Panel

Any required attachments may be submitted electronically on this panel. Note that attachments sent by mail, email or fax cannot be accepted. These must be added to the attachments and fees panel of the application.

Attachments Section

Not all documents listed under Supporting Documentation may apply to the application being submitted.

The user will need to scan and attach:

- Insurance face sheet for Nursing Facilities.
- License or certifications (if applicable)
- W-9 signed and dated within the past 6 months (if applicable)

- Voided check or bank letter dated within the past 6 months (if applicable)
- For each MCO or RAE contracted with, attach a copy of one of the following if network participation has been indicated in the enrollment application:
    - A completed Network Participation Verification Form; or
    - The contract panel(s) that identifies the contracting parties, the program name (e.g., Denver Health Medicaid Choice, Colorado Access, etc.) and the panel(s) with signatures of both parties, including the date; or
    - The entire contract with the MCO or RAE.
- Proof of Lawful Presence form (***only*** required for Billing Individuals or Atypical providers billing under their SSN)
- Supervising Physician Signature Form (***only*** required for Registered Nurses)
- Hardship waiver request letter and supporting documentation (if applying for a hardship waiver). Refer to the Financial Hardship subsection below for more information.
- Proof of payment (if application fee has already been paid to Medicare or in another state for this location)
- Visit Information by Provider Type web page for additional documentation required for the provider type.

Visit the Provider Forms web page and select the Provider Enrollment & Update Forms drop-down to access any applicable forms that may need to be printed, completed, signed and uploaded to the enrollment application.

If the user is attaching a Gainwell Technologies form with the enrollment, read the forms carefully. Some forms will require the user to include additional attachments. For example, lawful presence also requires a photo ID. Behavioral Therapist form requires licenses, certifications, diplomas, etc.

To submit a required attachment, first click the appropriate link to open the document. Some documents can be completed electronically while others will require the user to print and scan a document. The user should work with internal IT support if they are unfamiliar with this process.

Application Fee Section

The Enrollment tool will also calculate any required Enrollment Fees and guide the user through the payment process.

The Affordable Care Act (ACA) requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidation and change of ownership, as required, and is assessed in full for each service location enrolled in Colorado Medicaid. Visit the Provider Enrollment web page for the current amount.

The Application Fee questions as shown in the panel below will only be displayed if the Enrollment Type selected previously should have a fee.

If the service location has enrolled or revalidated with Medicare or another state's Medicaid program (in the last 5 years) and paid an application fee, no fee is required. A copy of the receipt indicating payment is **not** required for proof of payment to Medicare. Proof of payment to another state's Medicaid program may be uploaded on this panel in the attachments section with a selection type of "Other".

Financial Hardship

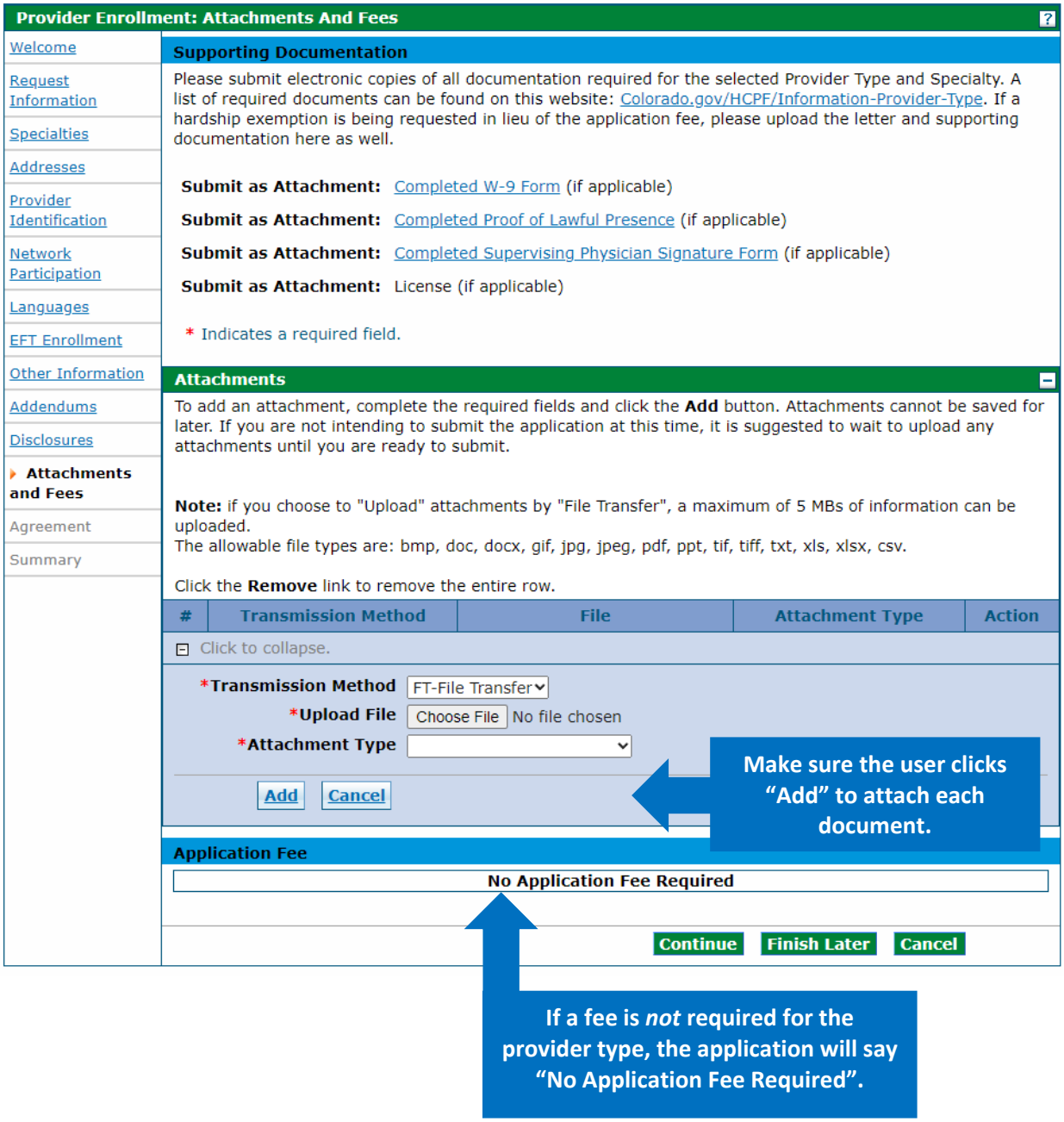
If the user is requesting a waiver for financial hardship, include a letter describing the financial hardship and why the hardship justifies an exception, as well as any additional supporting documentation that the user believes may aid the Department and CMS in the determination.

- Recommended supporting documentation includes most recent entity tax return(s), financial profit/loss exports (i.e., QuickBooks, Xero, etc.), three (3) or more bank statements and any additional documentation that would validate the hardship(s) indicated within the hardship letter.
    - Additional supporting documentation may include but is not limited to historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, liability obligations, tax returns, etc.

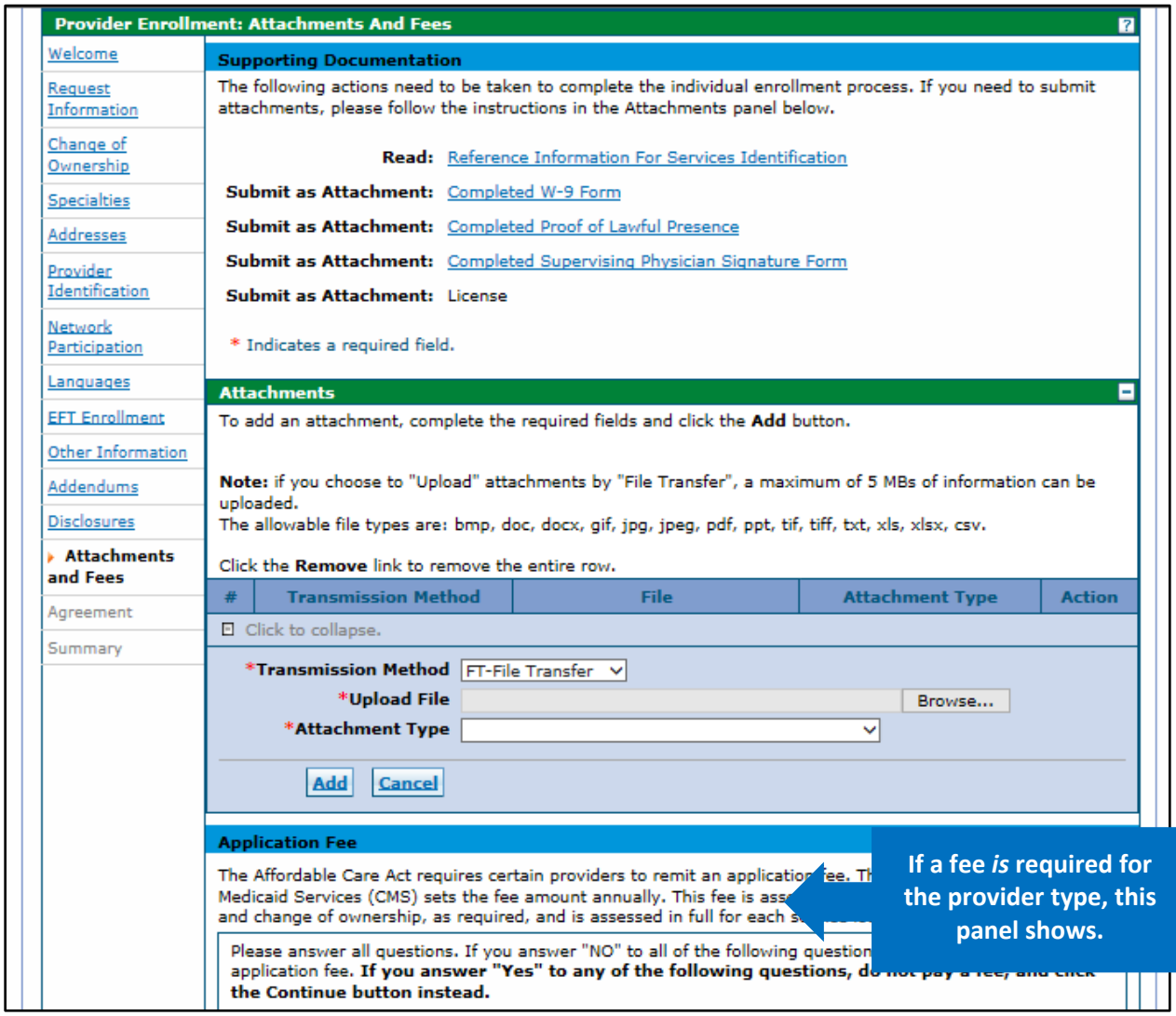
If the user chooses to apply for an application fee waiver, the enrollment will be delayed while a determination is made. The letter and supporting documentation must be uploaded on this panel in the attachments section with a selection type of “Other”.

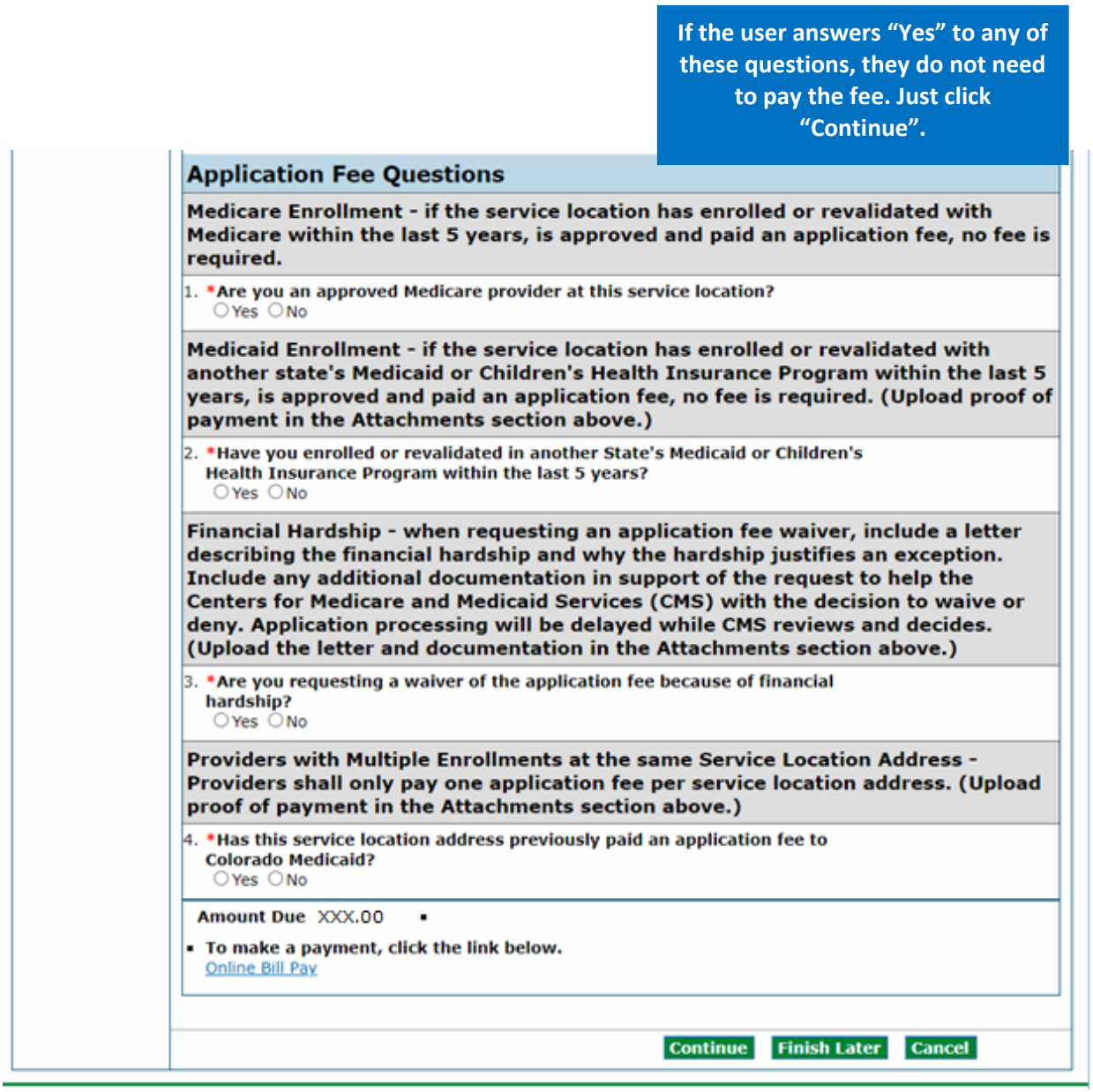
An example of the Attachments and Fees panel is shown below.

Attachments and Fees Panel – No Fee Required



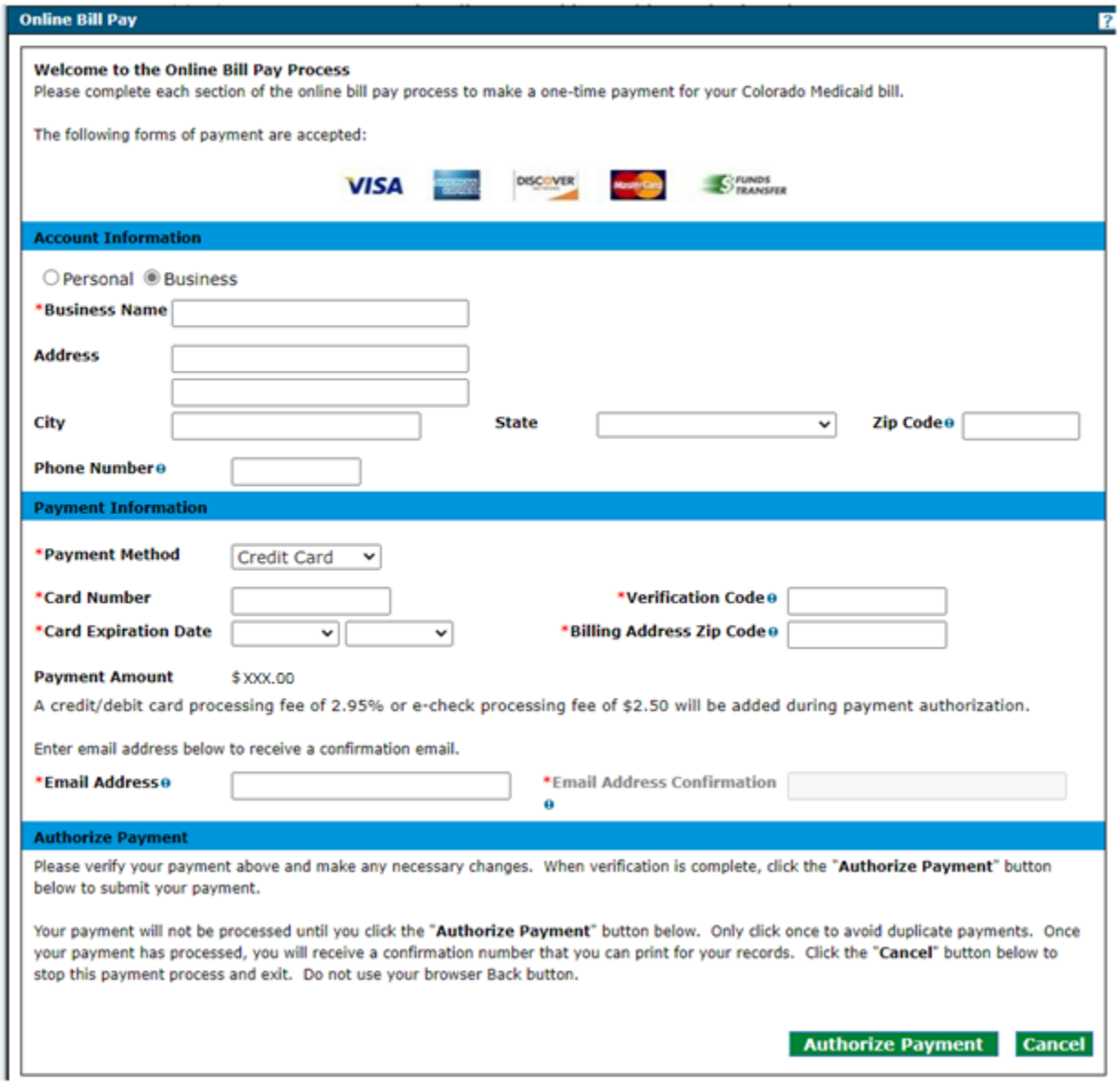
Attachments and Fees Panel – Fee Required





If it is determined that an application fee is due, click the "**Online Bill Pay**" link, and a payment form will open in a pop-up window:

Online Bill Pay Pop Up



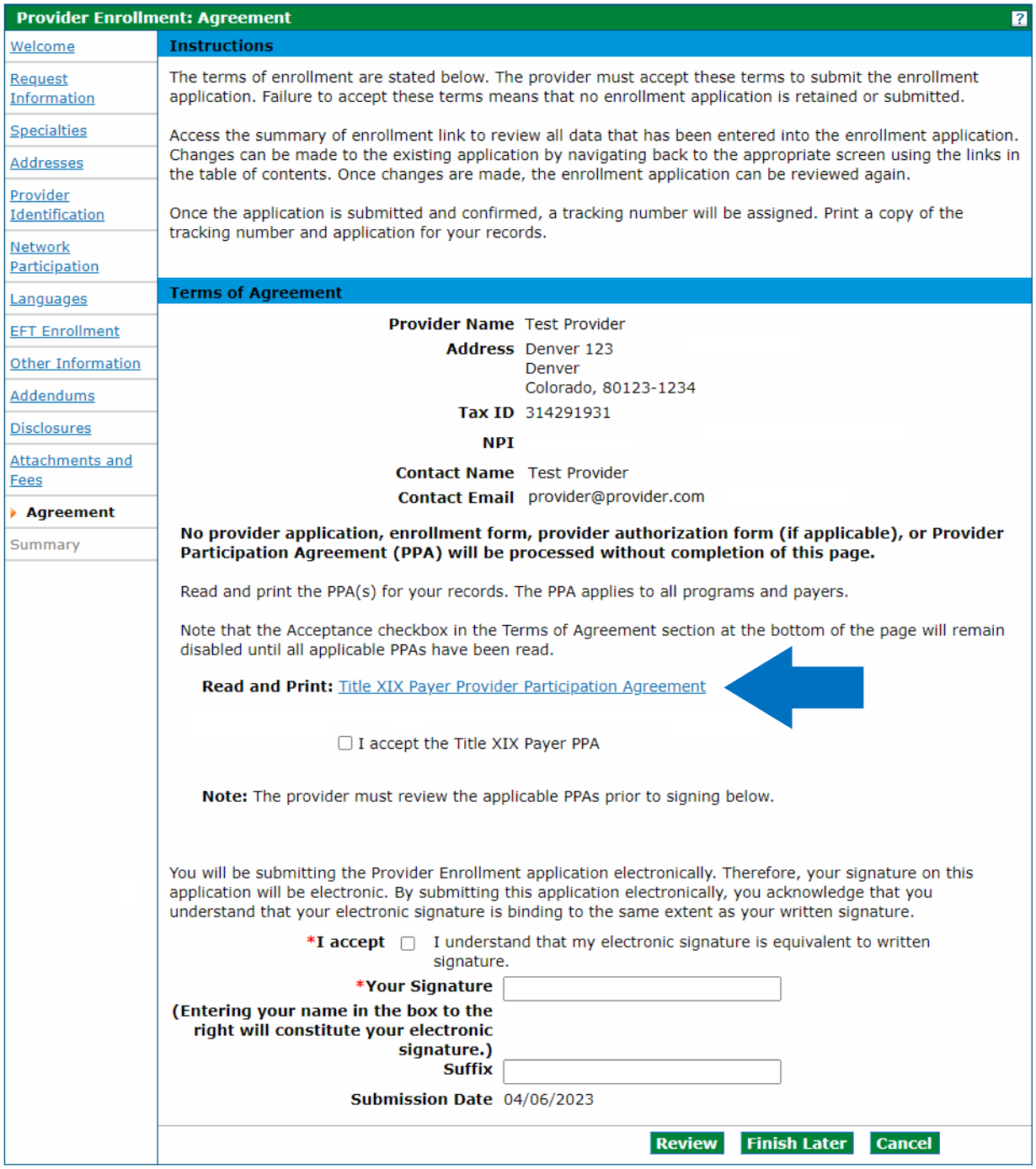
Note: A processing fee of 2.95% is charged for a debit/credit card payment, and a processing fee of $2.50 is charged for an e-check.

Agreement Panel

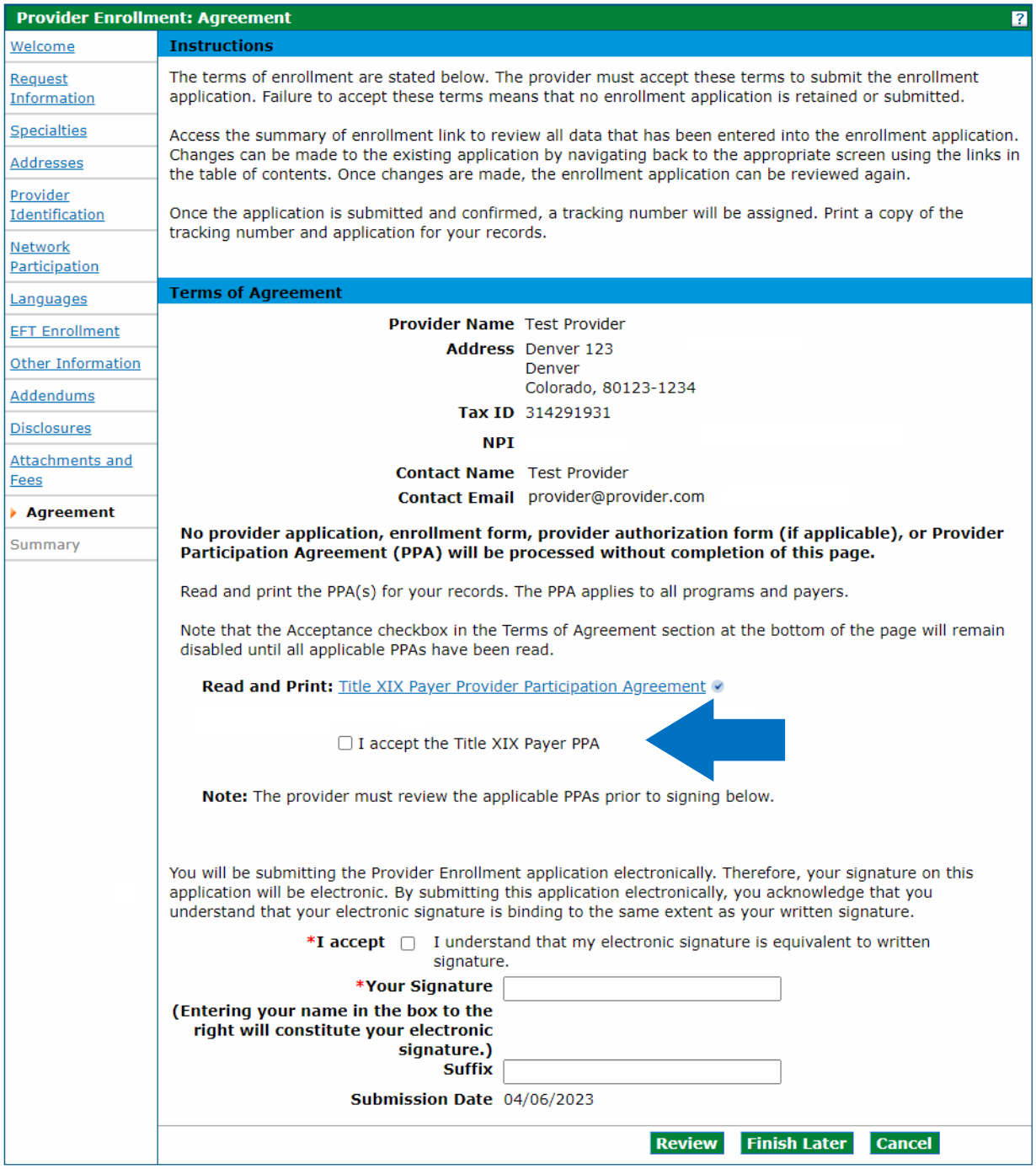
Note: The Agreement panel will not display for PACE-Only Subcontractor provider enrollment types.

Below is the Agreement panel. The terms of enrollment are stated here. Acceptance of these terms is required in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.

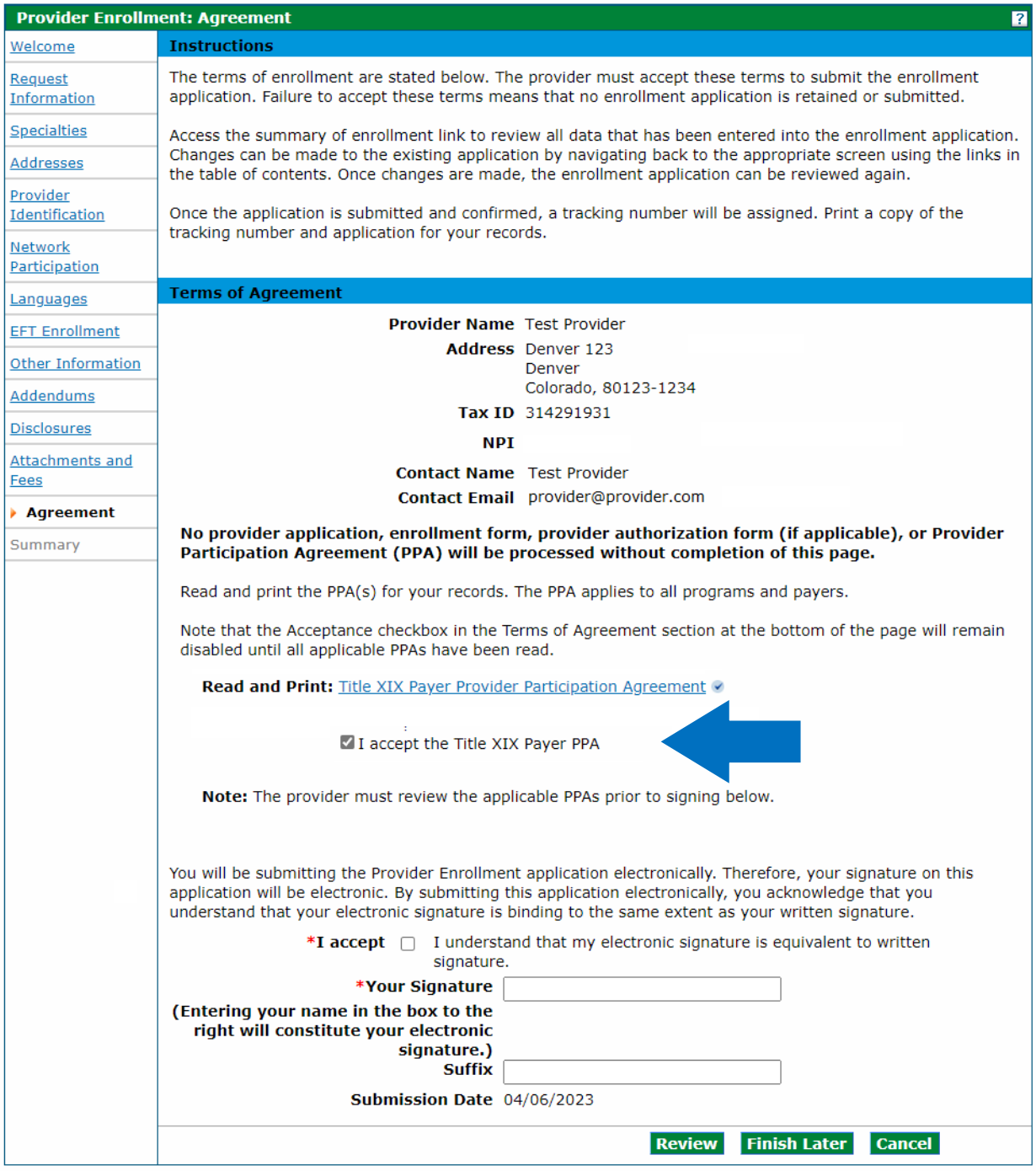
Click the link to the "**Provider Participation Agreement**" and read the agreement. If multiple Payers were selected, multiple Provider Participation Agreements will be displayed and will be required to be read and acknowledged to complete the panel.


Provider Enrollment: Agreement
Welcome
Request Information
Specialties
Addresses
Provider Identification
Network Participation
Languages
EFT Enrollment
Other Information
Addendums
Disclosures
Attachments and Fees
Agreement
Summary
Instructions
The terms of enrollment are stated below. The provider must accept these terms to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.
Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
Once the application is submitted and confirmed, a tracking number will be assigned. Print a copy of the tracking number and application for your records.
Terms of Agreement
Provider Name Test Provider
Address Denver 123
Denver
Colorado, 80123-1234
Tax ID 314291931
NPI
Contact Name Test Provider
Contact Email provider@provider.com
No provider application, enrollment form, provider authorization form (if applicable), or Provider Participation Agreement (PPA) will be processed without completion of this page.
Read and print the PPA(s) for your records. The PPA applies to all programs and payers.
Note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until all applicable PPAs have been read.
Read and Print: Title XIX Payer Provider Participation Agreement
I accept the Title XIX Payer PPA
Note: The provider must review the applicable PPAs prior to signing below.
You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.
*I accept
I understand that my electronic signature is equivalent to written signature.
*Your Signature
(Entering your name in the box to the right will constitute your electronic signature.)
Suffix
Submission Date 04/06/2023
Review
Finish Later
Cancel

Once complete, a checkmark will then appear next to it:



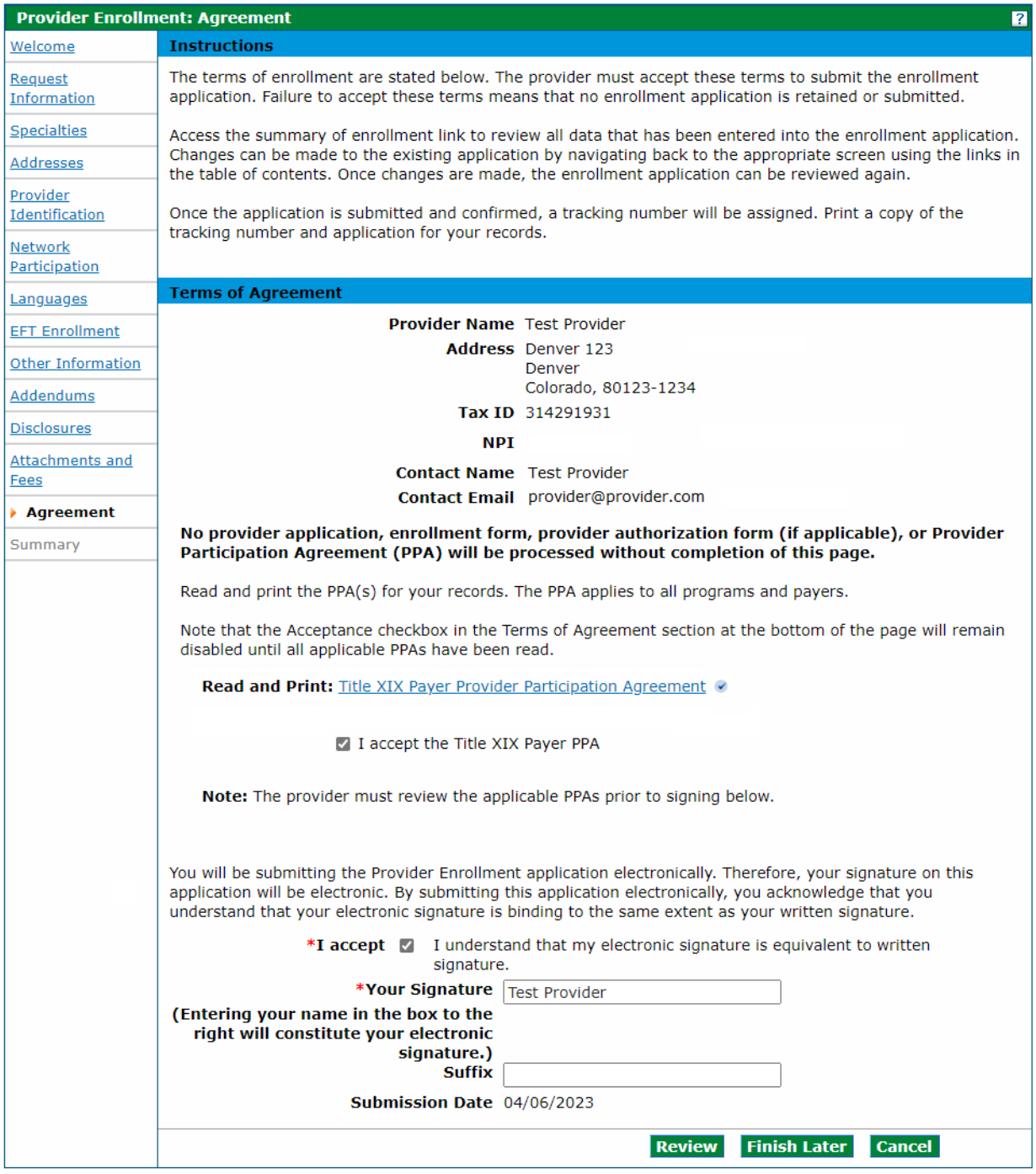
If the user does not print the provider participation agreement at this time, they may view a copy of this agreement on the Provider Forms web page.



Click the “I accept” checkbox for each Provider Participation Agreement.

Enter the Provider name as the electronic signature and click in the “**I accept**” box in order to complete the panel. The “**Review**” button will then become active:

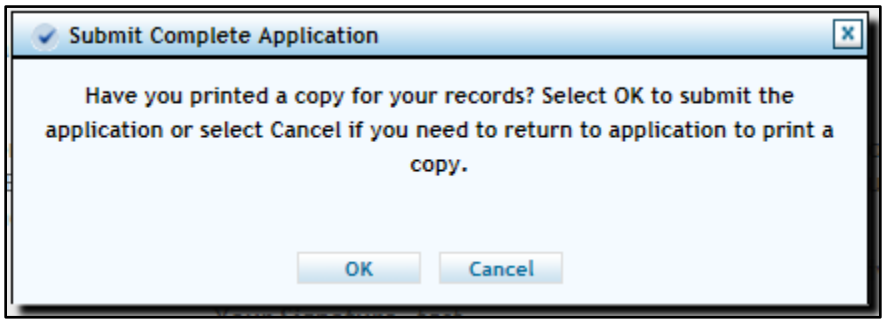
Agreement Panel - Provider Participation Agreement



Summary Panel

This panel will show the application in its entirety. At this point, the user should review all information that has been entered for accuracy. The user may be requested to confirm the information and print a copy of the summary.

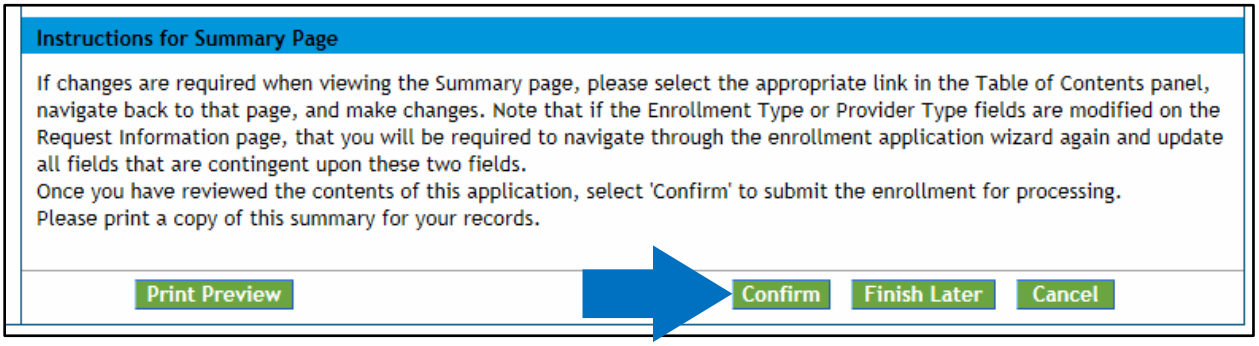
The user will be asked if they have printed a copy of this enrollment for your records. If the user has already printed a copy, or do not wish to print a copy, click "**OK**". If the user would like to print a copy and has not done so yet, click "**Cancel**" to return to the application to print a copy.



Once the confirmation dialog box shown above disappears, click "**Confirm**" to submit the application for processing.

The application is not submitted for processing until the Confirm button at the bottom of the summary page is clicked:

Enrollment Summary Panel – Confirm Button – Application Submission



If the user has not previously saved the application, they will be prompted to set up a password and security questions as reviewed in the 'Completing Application' section of the manual.

After the Application Is Submitted

Visit the Next Steps after Enrollment Application web page for further instructions.

Resources

The Provider Manual is also supplemented with the Provider FAQ Central web page. This list is updated often and should be bookmarked for future reference.

For additional support, providers may contact Gainwell Technologies, Fiscal Agent for Health First Colorado, by calling the Provider Services Call Center at 1-844-235-2387.

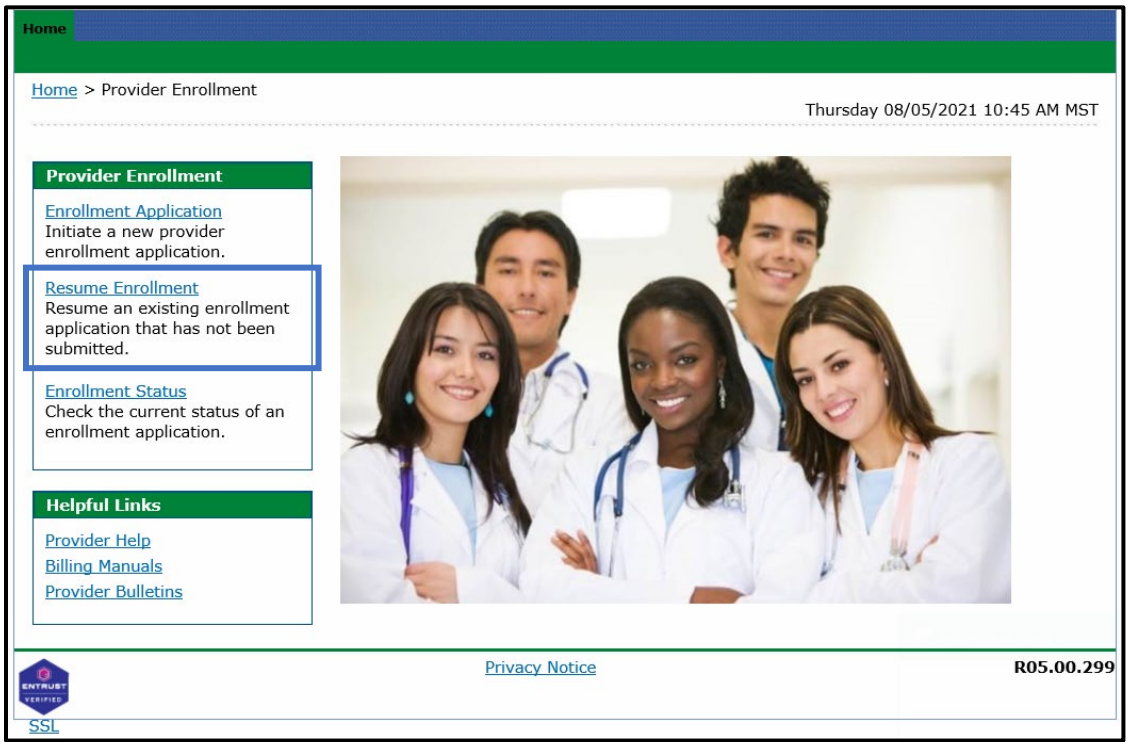
Additionally, providers may visit the Provider Enrollment web page for additional information.

Resume Enrollment

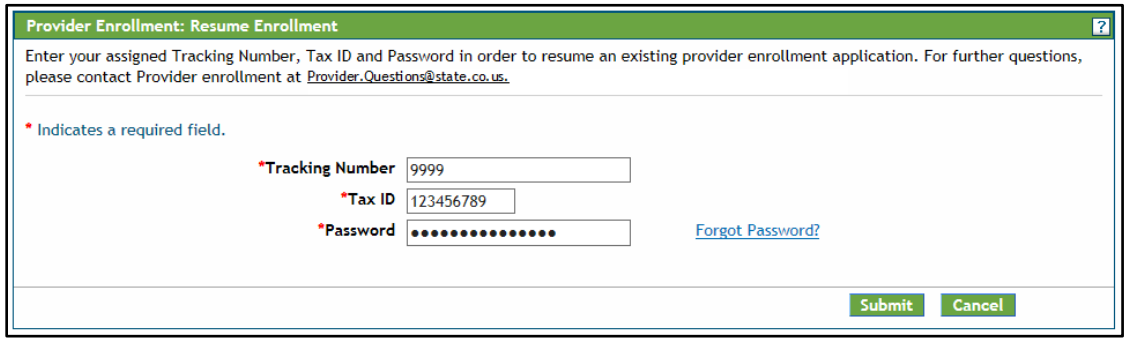
If the user was unable to complete the enrollment process and elected to save the work, the application process can be resumed with the "Resume Enrollment" link as shown below. If the application was completed, but the user received an email from Gainwell Technologies stating additional or corrected information is needed, use the same link.

Unless an application is returned to a provider for updates or corrections, no changes may be made to information entered in the Provider Portal once the application is submitted.

Provider Portal - Resume Enrollment Link



Provider Portal - Resume Enrollment - Login



The Tax ID entered here must be an exact match to the Tax ID that was entered as enrolling on the application.

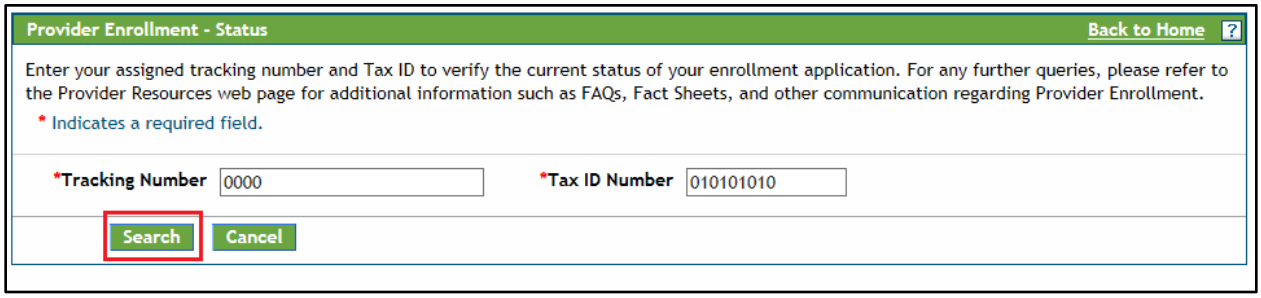
Enrollment Status

Providers may check the current status of applications using the **Enrollment Status** link shown below.

Provider Portal - Enrollment Status Link

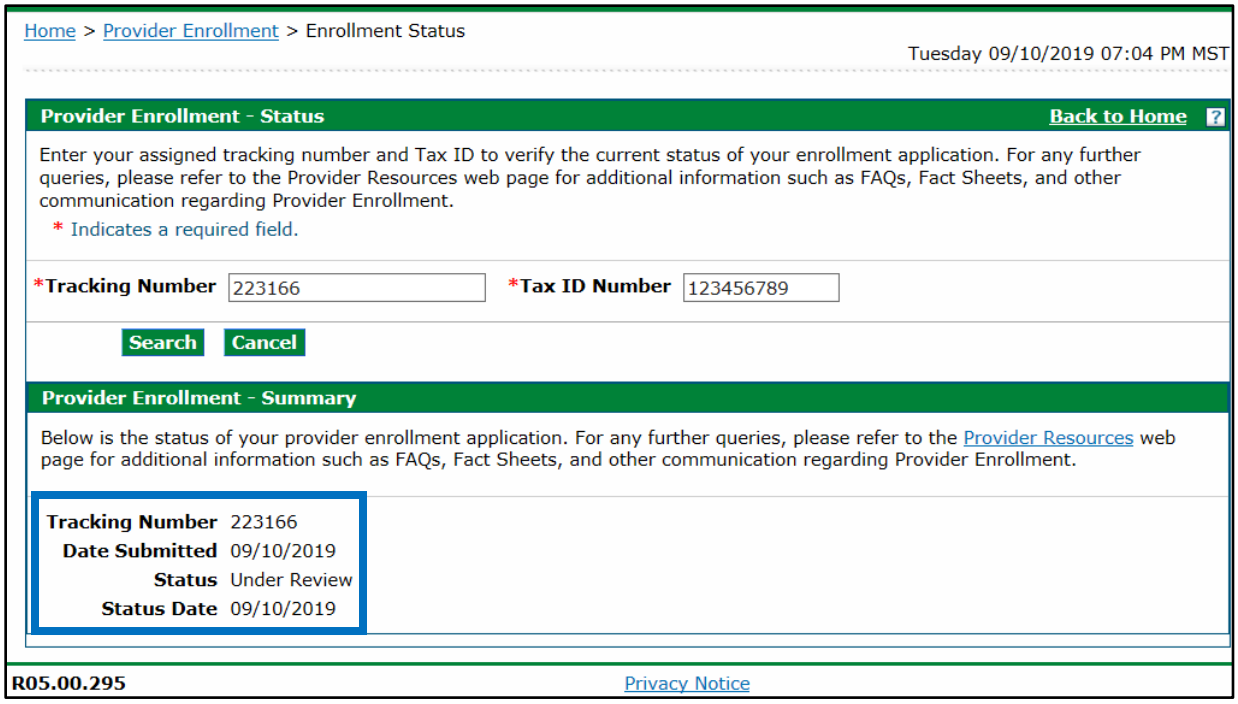
Enrollment Status Login

Click the **Enrollment Status** link shown above. Enter the Application Tracking Number (ATN) and Tax ID Number (TIN), then click **Search**.



The Provider Enrollment - Summary panel will then display showing the current status of the application:

Enrollment Status – Summary



Even if there are notes here indicating the application needs to be returned to the provider, the user ***will not*** be able to re-enter the application to make corrections until this status reads 'Returned to provider for Additional Information', 'Returned to provider for Additional Authorization(s)' or 'Returned to provider for Missing Documentation'.

Once the application is returned, an email is sent to the contact email address from the application, to notify contact of the status.

To make the required corrections, the user will need to log back into the application by clicking **Resume Enrollment (refer to the previous section)**. The user will then need to click the Continue button at the bottom of each panel to navigate through the application.

Site Visits

Per federal requirement 42CFR 455.432, pre-enrollment site visits of providers who are designated as "moderate" or "high" categorical risks to the Medicaid program are required.

The purpose is to verify that the information submitted to the Department of Health Care Policy and Financing by a provider is accurate and to determine compliance with federal and state enrollment requirements. If the provider type falls into one of these risk categories, the user will be contacted for the required site visit. A representative will visit the service location to verify certain aspects of the enrollment. Providers that refuse a site visit may be excluded from the Colorado Medicaid Program.

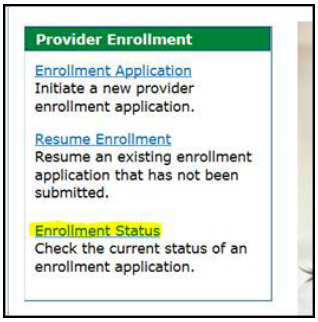
Refer to the risk levels on the Information by Provider Type web page for further information about risk categories by provider type.

File a Grievance

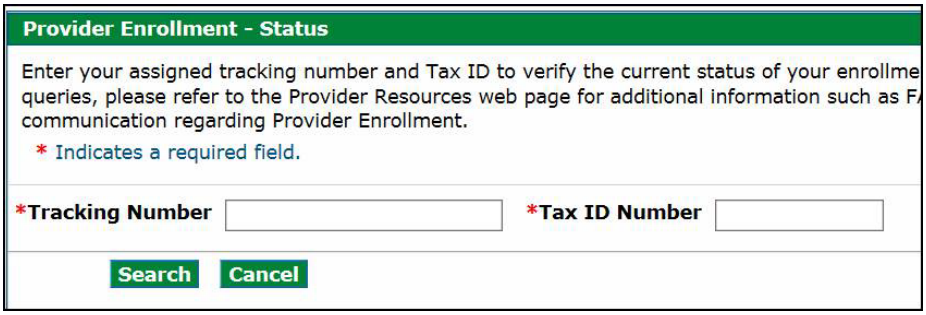
Follow this process to file a grievance if the application is denied for enrollment and the provider disagrees with the decision.

1. Go to the Provider Enrollment Portal Home page.
2. Click **Provider enrollment**.

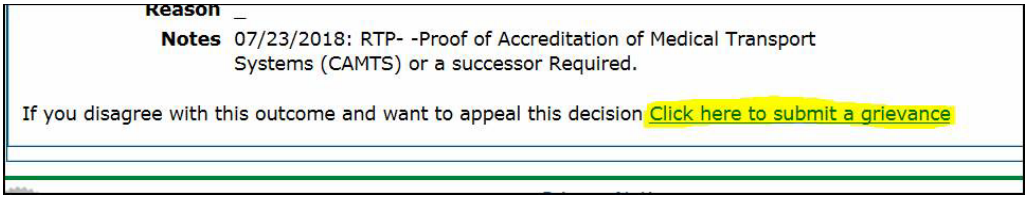
3. Click **Enrollment Status**.



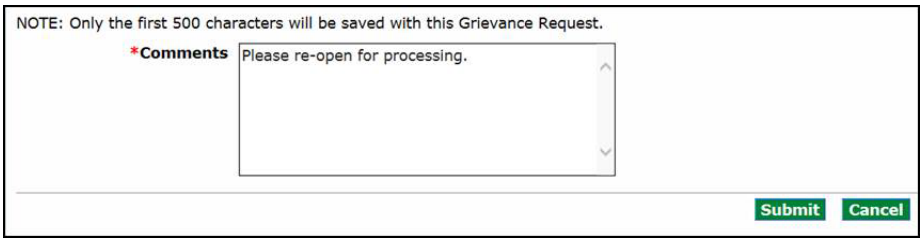
4. Enter the Tracking Number (ATN) and Tax ID Number (TIN) from the ATN, then click **Search**.



5. Scroll to the bottom of the page and click the **Click here to submit a grievance** link.



6. Enter the reason for disagreeing with the decision and click **Submit**.



Result: The grievance has been filed and will be reviewed by Gainwell Technologies. The provider will receive the following notification once the grievance has been approved:

The application is now back in "Under Review" status and will be reviewed again by a Gainwell Technologies analyst.

Provider Enrollment Notifications

The applicant will receive several notifications via email during the Enrollment Process:

- Upon successful submission of an online enrollment application for review, the applicant will receive an email at the email address entered in the contact information during the enrollment process acknowledging the submission.
- During the application review process by Gainwell Technologies, if additional information and/or missing documentation is needed, an email will be sent to the email address entered in the contact information during the enrollment process. The applicant will then be able to return to the application on the web portal to address the issues through the "Resume Enrollment" link. Once this is completed, Gainwell Technologies will be notified of the application update and will continue processing.
- Once the application has been reviewed another email will be sent to the address entered in the contact information during the enrollment process advising the applicant of the outcome.
    - If the application is approved, the user will be advised that they are enrolled but that they must complete certain steps with the current fiscal agent in order to begin billing for services.
        - Once the application has been approved for enrollment, the user will receive instructions for registering their assigned provider ID number in the provider web portal. Registration instructions may also be viewed in the Provider Web Portal Registration Quick Guide web page.
          Note: PACE-Only Subcontractors cannot register for the Provider Web Portal and must contact the Provider Services Call Center to update their provider information or disenroll.
    - If the application is rejected, the user will be advised of the reason and their rights to file a grievance. Refer to the File a Grievance section for more information.

Forms

To access any applicable forms that may need to be printed, completed, signed and uploaded to the enrollment application, visit the Provider Forms web page and select the Provider Enrollment & Update Forms drop-down.