COLORADO

MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

Fiscal Agent for the
Colorado Medical Assistance Program

ACS
A xerox Company

PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757 or 1-800-237-0044
colorado.gov/hcpf

Name and Business Organization Information

All applicants must complete

☒ **This Is For EDI Enrollment Only**

1 Name and Type of Business Practice

Provider Number_____ **NPI Number**_____

Tax ID_____ **or Social Security Number**_____

Individual Name

_____ _____ _____ _____

Individuals Last Name | First Name | M.I. | Title/Degree

Business ventures (sole proprietors, groups, partnerships, and corporations) (Applying under a Tax ID)

_____

Legal business name (exactly as registered with the Internal Revenue Service)

_____

Doing Business As (DBA) name (if applicable)

Institutions (Hospitals)

_____

Legal business name (exactly as registered with the Internal Revenue Service)

_____

Doing Business As (DBA) name (if applicable)

This space for fiscal agent use

Provider Address and Contact Information

All applicants must complete

2 Mailing Address & Phone Information

_____
Address

_____ City _____ County _____ State _____ Zip

Telephone ( ) _____ Fax ( ) _____

3 Contact Information

Primary Contact Information/Trading Partner Administrator

Contact Individual Name: _____ First Name _____ Last Name Contact Title: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Business email address: _____

Secondary Contact Information/Trading Partner Administrator

Contact Individual Name: _____ First Name _____ Last Name Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Business email address: _____

Provider/Submitter Electronic Information

All applicants must complete

Colorado Medical Assistance Program rules (8.040.2) require the electronic submission of claims except in certain circumstances. Providers may also retrieve reports electronically. In order to electronically submit claims, or electronically retrieve reports, applicants must complete these sections.

4 Please indicate how you plan to submit your electronic transactions

Electronic Transactions

- ☐ Vendor Software
- ☐ Billing Agent
- ☐ Clearinghouse/Switch Vendor
- ☒ State's Provider Web Portal

Transactions available for transmission

- ☒ X12N 270 (Eligibility Inquiry)
- ☒ X12N 276 (Claim Status Inquiry)
- ☒ X12N 278 (Prior Authorization)
- ☒ X12N 837P (Professional Claim)
- ☒ X12N 837D (Dental Claim)
- ☒ X12N 837I (Institutional Claim)

5 Electronic Report/ Response Retrieval

If you are currently submitting electronic transactions directly to ACS EDI Gateway, please indicate your 5-digit Submitter ID or 6-digit Trading Partner ID.

☐☐☐☐☐☐

All software vendors must have their own uniquely assigned Submitter or Trading Partner ID to act on your behalf. Please contact your software vendor to confirm their status. Please enter your software vendor's 5-digit Submitter ID or 6-digit Trading Partner ID.

☐☐☐☐☐☐

Software Product _____

Transactions Available for Receiving Reports

Colorado Medical Assistance Program providers can receive X12N electronic reports. Please select the reports that you want to receive through the State's Provider Web Portal. *Enter only one Trading Partner (TP) ID per report. You may enter a different TP ID for each selected report.*

- ☒ X12N 824 (Payer Specific Error Report) will by default be returned to submitting TP ID
- ☒ X12N 271 (Eligibility Response) will by default be returned to submitting TP ID
- ☒ X12N 997 (Acknowledgement of a sent transaction) will by default be returned to submitting TP ID
- ☒ X12N 277 (Claim Status Response) will by default be returned to submitting TP ID

If the Receiving TP ID field is left blank, it will by default be returned to submitting provider's TP ID

	Receiving TP ID		Receiving TP ID
☐ X12N 820 (Client Capitation)	_____	☐ X12N 835 (Claim payment/Claim report	_____
☒ Accept/Reject Report	_____	☒ Provider Claim Report (Previously called the Remittance Advice Report)	_____
☐ PCP Roster	_____	☐ Managed Care Transactions	_____
☐ X12N 834 (Benefit Enrollment and Maintenance)	_____	☐ ACC Roster Report	_____
☒ PAR Letters	_____		

Element Delimiter to be used: ☐ Default Delimiter (asterisk) *****

Sub-element Delimiter to be used: ☐ Default Delimiter (colon) :

Segment Delimiter to be used: ☐ Default Delimiter (tilde) ~

The Department will provide you with more information at a later date, including a User ID and Password, under separate cover.

EDI Provider Authorization Form

This Authorization must be completed and signed by the provider who wishes to authorize a billing agent, clearinghouse or other provider to:

- *Maintain and control designated reports*
- *Submit and/or retrieve designated transactions*

*The authorized billing agent, clearinghouse, or provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.*

Provider, _____ hereby appoints
Provider Name (please print)

_____, _____
Billing Agent/Clearinghouse/Provider Name (please print) Billing Agent/Clearinghouse/Provider Trading Partner/Submitter ID

to act as an authorized agent for the purpose of submitting health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program.
Provider must check one box below:

☐ **Provider authorizes the listed agent to retrieve some or all electronic reports/responses on Provider's behalf.**

OR

☐ **Provider does NOT authorize the listed agent to retrieve electronic reports/responses on Provider's behalf.**

_____
Provider/Provider Representative Name (please print)

_____ _____
Provider/Provider Representative Signature Date

_____
Provider Number

This Authorization may be modified or revoked at any time in writing. It is considered in effect until modified or revoked.

This form must be completed by the billing provider <u>not</u> a rendering provider.

All applicants must complete

Note: All those providers with a current Colorado Medical Assistance Program Provider ID number, or those providers submitting an application to become a Colorado Medical Assistance Program Provider MUST EXECUTE AND RETURN this Provider Participation Agreement.

PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement ("Agreement") is entered into by and between the Colorado Department of Health Care Policy and Financing ("Department"), it's fiscal agent, ACS State Healthcare, LLC ("ACS"), and

_____ , _____ ,
(Provider Name) (Provider Number)

("Provider"), collectively "the Parties." This Agreement is entered into in order to define Department expectations of providers who perform services and submit billing, transactions, and/or data to the Colorado Medical Assistance Program. This Agreement is also established to facilitate business transactions by electronically transmitting and receiving data in agreed formats; to ensure the integrity, security, and confidentiality of the aforesaid data; and to permit appropriate disclosure and use of such data as permitted by law. This Agreement is to be considered in conjunction with the Provider Enrollment Form, if necessarily completed.

RECITALS

A. The Colorado Department of Health Care Policy and Financing is the single state agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act.

B. ACS has developed, on behalf of the Colorado Department of Health Care Policy and Financing, a paperless transaction system that will process Colorado Medical Assistance Program electronic transactions submitted through the designated electronic media.

C. ACS is the contracted Fiscal Agent for the Colorado Department of Health Care Policy and Financing, which is responsible for administration of the Colorado Medical Assistance Program. Although ACS operates the computer system translator through which electronic transactions flow, the Department retains ownership of the data itself. Providers access the pipeline network through various means, over which the transmission of electronic data occurs. Accordingly, providers are required to transport data to and from ACS.

D. Electronic transmission of any/all data shall be in strict accordance with the standards set forth in this Agreement and as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under by the U.S. Department of Health and Human Services and other applicable laws, as amended.

E. This Agreement is subject to modification, revision, or termination according to changes in federal or state laws, rules, or regulations. This Agreement will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

F. This Agreement delineates the responsibilities of the Parties, and any agent, subcontractor, or employee of a Party, in regard to the Colorado Medical Assistance Program. As consideration for acceptance as an enrolled provider in the Colorado Medical Assistance Program, the Provider certifies and agrees to the terms and conditions set forth below.

All applicants must complete

DEFINITIONS

For the purpose of this Agreement:

A. "Colorado Department of Health Care Policy and Financing" means the Colorado State governmental agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act.

B. "Standard" is defined in 45 C.F.R. §160.103.

C. "Provider" refers to any health care provider with a current Colorado Medical Assistance Program Provider ID number or any health care provider submitting an application to become a Colorado Medical Assistance Program Provider. "Provider" also includes all agents, subcontractors, or employees of a Colorado Medical Assistance Program Provider.

D. "Transaction" is defined in 45 C.F.R. §160.103.

E. "Transactions and Code Set Regulations" mean those regulations governing the transmission of certain health claims transactions as promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. Parts 160 and 162.

PROVIDER PARTICIPATION

A. Provider will comply with all applicable provisions of the Social Security Act, as amended; federal or state laws, regulations, and guidelines; and Department rules. Provider will limit the use or disclosure of information/data concerning Colorado Medical Assistance Program clients to the purposes directly connected with the administration of the Colorado Medical Assistance Program.

B. Provider will accept full legal responsibility for all claims submitted under the Provider's Colorado Medical Assistance Program ID number to the Colorado Medical Assistance Program and will comply with all federal and state civil and criminal statutes, regulations and rules relating to the delivery of benefits to eligible individuals and to the submission of claims for such benefits. Provider understands that non-compliance could result in no payment for services rendered.

C. Provider will request payment only for those services which are medically necessary or considered covered preventive services, and rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision. Claims will be submitted only for those benefits provided by health care personnel who meet the professional qualifications established by the State. Provider understands that any misrepresentation or falsification by another may result in fine and/or imprisonment under state or federal law.

D. Provider will maintain records that fully and accurately disclose the nature and extent of benefits provided to eligible clients/patients in accordance with the regulations of the Department. Provider will maintain licensure and/or certification granted by the State licensing agency that regulates the services that are provided, and will make disclosure of ownership and provide access to medical records and billing information to the Department, or its designees, as required by federal and state laws and regulations.

E. Provider records will be maintained for six (6) years unless an additional retention period is required under state or federal regulations, such as an audit started before the six (6) year period ended or based on a specific contract between the Provider and the Department.

All applicants must complete

F. The US Department of Health and Human Services, the Department, or the State Attorney General's Medicaid Fraud Control Unit, or their designees, has the right to audit and confirm for any purpose any information submitted by the Provider. Provider agrees to furnish information about submitted claims, any claim documentation records, and original source documentation; including provider and patient signatures, medical and financial records in the Provider's office or any other place, and any other relevant information upon request. Any and all incorrect payments discovered as a result of an audit will be adjusted or fully recovered according to the applicable provisions of the Social Security Act, as amended, federal or state laws, regulations, and guidelines.

G. Provider agrees to accept as payment in full, amounts paid in accordance with schedules established by the Department. No supplemental charges will be billed to the client, except for amounts designated as co-payments by the Department. Provider will not bill the client for any covered items or services that are reimbursable under the rules and regulations of the Department, or for any items or services that are not reimbursable but would have been had the Provider complied with the rules and regulations of the Department. All payments received or applied from any other sources will be recorded on the claim.

H. Provider certifies that items and services provided will be available without discrimination as to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, handicap, or national origin. Provider hereby certifies compliance with Section 504 of the Rehabilitation Act of 1973 which provides that, " no otherwise qualified handicapped individual...shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

I. If, at any time from the date of this agreement, the Department determines that Provider has failed to maintain compliance with any state or federal laws, rules, or regulations, Provider may be suspended from participation in the Medical Assistance Program, and may be subjected to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

J. Department payment by electronic funds transfer (EFT) and advisement by deposit notice or remittance statement represents Provider's confirmation that funds were accepted for services rendered and billed.

K. Provider, and person signing the claim or submitting electronic claims on Provider's behalf, understand that failure to comply with any of the above in a true and accurate manner will result in any available administrative or criminal action available to the Department, the State Attorney General's Medicaid Fraud Control Unit, or other government agencies. The knowing submission of false claims or causing another to submit false claims may subject the persons responsible to criminal charges, civil penalties, and/or forfeitures.

GENERAL ELECTRONIC DATA INTERCHANGE TERMS AND CONDITIONS

(only applicable to those providers submitting and receiving data electronically)

A. The Parties agree to submit claims and exchange data electronically using only those approved Transaction types and formats (versions) as selected by Provider within the Provider Enrollment Form.

B. For electronic claims, Provider will ensure that all required provider and patient signatures, including, where applicable, appropriate signatures on behalf of the patient, and required physician certifications are on file in the Provider's office.

C. Transactions/documents will be transmitted electronically either directly or through a contracted third-party service provider, such as a vendor, billing agent, or clearinghouse. Provider may modify its election to use, not use, or change a third-party service provider by updating the Provider Enrollment Form. Provider will be responsible for the costs of any third-party service provider with which it contracts, and will ensure that any third-party service provider contracted will properly institute and adhere to those procedures reasonably calculated to provide appropriate levels of security for the authorized transmission of data, and protection from improper access. No Party accepts responsibility for technical or operational difficulties that arise out of third-party service providers' business obligations and requirements that undermine the Transaction exchange between Provider and ACS.

D. The Parties will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically, as per 45 C.F.R. §162.915.

E. The Parties will not add any data elements or segments to the maximum defined data set, as per 45 C.F.R. §162.915.

F. The Parties will not use any code or data elements that are either marked "not used" in a standard's implementation specification or are not in the standard's implementation specification(s), as per 45 C.F.R. §162.915.

G. The Parties will not change the meaning or intent of a Standard's implementation specification(s), as per 45 C.F.R. §162.915.

H. ACS will accept Transactions from Provider according to the Provider Enrollment Form, but may subsequently deny a Transaction for further processing if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the Provider Enrollment Form. ACS may return Provider to a test status if Provider repeatedly submits Transactions that do not meet the criteria set forth in the Provider Enrollment Form or if Provider repeatedly submits inaccurate or incomplete Transactions to ACS.

I. Provider understands that ACS or others may request an exception from the Transaction and Code Set Regulations from the U.S. Department of Health and Human Services. If an exception is granted, Provider will participate fully with ACS in the testing, verification, and implementation of a modification to a Transaction affected by the change.

J. Provider and ACS agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer, as per 45 C.F.R. §162.925(c)(2).

K. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving Party. Once transmissions are properly received, the receiving Party will promptly transmit an electronic acknowledgement that conclusively constitutes evidence of properly received Transactions. Each Party will subject information to a virus check before transmission to the other Party.

L. ACS may publish data clarifications ("Companion Guides") to complement each Implementation Guide. HIPAA Implementation Guides are available at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. Companion Guides are available in the Provider Services Specifications section of the Department's Web site at colorado.gov/hcpf.

ELECTRONIC CONFIDENTIALITY, PRIVACY AND SECURITY

(only applicable to those providers submitting and receiving data electronically)

A. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Regulations (45 C.F.R. Parts 160 and 164) apply to all health plans, health care clearinghouses, and health care providers that transmit protected health information in electronic transactions; and extends to any business associate working on behalf of a covered entity. As such, it is expected that all Parties will implement and maintain appropriate policies, procedures, and mechanisms to protect the privacy and security of protected health information that is maintained by, and transmitted between, the Parties.

B. The Parties agree that any electronic protected health information furnished to one Party by any other Party will be used only as authorized under the terms and conditions of this Agreement and the Provider Enrollment Form, and may not be further disclosed. The Parties will establish appropriate administrative, technical, procedural, and physical safeguards to ensure the confidentiality, integrity, and availability of all electronic protected health information that is created, received, maintained, or transmitted as part of this Agreement. Provider will obtain satisfactory assurance and documentation thereof, as required by 45 C.F.R. §164.502(e), from any business associate with whom it contracts, and any subcontractors thereof, that all protected health information covered by this Agreement will be appropriately safeguarded.

C. Provider agrees that in the event the Department determines, or has a reasonable belief that Provider has made or may have made disclosure of Colorado Medical Assistance Program client protected health information that is not authorized by this Agreement, the Provider Enrollment Form, or other written Department authorization, the Department, in its sole discretion, may require ACS and/or Provider to: (a) promptly investigate and report to the Department determinations regarding any alleged or actual unauthorized disclosure; (b) promptly resolve any problems identified by the investigation; (c) submit a formal written response to an allegation of unauthorized disclosure; (d) submit a corrective action plan with steps designed to prevent any future unauthorized disclosures; and/or (e) return data to the Department.

ASSIGNMENT OF AGREEMENT

A. This Agreement is entered into solely between, and may be enforced only by the Parties. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of the Parties to any third party.

B. No Party may assign this Agreement without the prior written consent of the Department, and such consent may not be unreasonably withheld.

MODIFICATIONS

A. This Agreement contains the entire agreement between the Parties and supersedes any previous understanding, commitment or agreements, oral or written, concerning the electronic exchange of information/data. Any change to this Agreement will be effective only when set forth in writing and executed by all Parties.

DISPUTES AND LIMITATION OF LIABILITY

A. This Agreement will be interpreted consistently with all applicable federal and state laws. In the event of a conflict between applicable laws, the more stringent law will be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement will be governed by and construed in accordance with Colorado law, exclusive of conflicts of law principles. The exclusive jurisdiction for any legal proceeding regarding this agreement shall be in the courts of the State of Colorado and the Parties hereby expressly submit to such jurisdiction.

B. Parties will use reasonable efforts to assure that the information – data, electronic files and documents supplied hereunder – are accurate. However, Provider shall indemnify, save, and hold harmless the Department, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the Provider, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement

C. Notwithstanding anything herein to the contrary, no term or condition shall be deemed, construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or provisions, of the "Colorado Governmental Immunity Act", 24-10-101, et seq., C.R.S., as now or hereafter amended ("Immunity Act"), nor of the Risk Management self-insurance statutes at 24-30-1501, et seq., C.R.S., as now or hereafter amended ("Risk Management Act"). The Parties understand and agree that the liability of the State of Colorado, its departments, institutions, agencies, boards, officials and employees is controlled and limited by the provisions of the Immunity Act and the Risk Management Act, as now or hereafter amended. Any provision of this Agreement, whether or not incorporated herein by reference, shall be controlled, limited, and otherwise modified so as to limit any liability of the State to the above cited laws. In no event will the State be liable for any special, indirect, or consequential damages, even if the State has been advised of the possibility thereof.

D. DISCLAIMER OF WARRANTIES. THE PARTIES HEREBY EXCLUDE ALL EXPRESS AND IMPLIED WARRANTIES, INCLUDING BUT NOT LIMITED TO THE IMPLIED WARRANTIES OF MERCHANTABILITY AND THE IMPLIED WARRANTY OF FITNESS FOR A PARTICULAR PURPOSE. THERE ARE NO WARRANTIES WHICH EXTEND BEYOND THE DESCRIPTION OF THE FACE OF THIS AGREEMENT.

E. Provider warrants and represents that at the time of entering into this Agreement, neither Provider nor any of its employees, contractors, subcontractors or agents are identified on the HHS/OIG List of Excluded Individuals/Entities (available at http://www.oig.hhs.gov/FRAUD/exclusions/listofexcluded.html). In the event Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Provider shall have an obligation to immediately notify the Department of such ineligible person status and within ten days of such notice, remove such individual from responsibility for, or involvement with the Providers business operations related to this Agreement.

TERMINATION

A. This Agreement shall remain in effect until terminated by any Party with not less than thirty (30) days prior written notice to the other Parties. Such notice shall specify the effective date of termination. In the event of a material breach of this Agreement by Provider, as determined by the Department, the Department may terminate the Agreement by giving written notice to the breaching Provider. The breaching Provider shall have thirty (30) days to fully cure the breach. If the breach is not cured within thirty (30) days after the written notice is received by the breaching Provider, this Agreement shall automatically and immediately terminate.

B. This Agreement may be terminated by the Department if the contract between the Department and ACS expires or terminates. Provider enrollment records will survive assignment of a new Department fiscal agent unless provider re-enrollment is explicitly initiated by the Department

TERM OF AGREEMENT

A. This Agreement is effective for the entire term of enrollment. This Agreement shall continue until terminated.

All applicants must complete

PROVIDER SIGNATURE PAGE

NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE

I certify by my signature below that I am fully authorized to sign and execute this Agreement on behalf of Provider; and that I have read, understand, certify, and agree to all the statements made above in all parts of this Provider Participation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a Colorado Medical Assistance Program Provider, and/or may be prosecuted under applicable federal and state laws.

Provider

By: _____

Provider/Provider Representative Signature

(If the provider is an ICF/MR, by signing this update request, the ICF/MR agrees to the update changes only, the original ICF/MR agreement remains unchanged.)

Name: _____

Provider/Provider Representative Name (please print)

Title: _____

Provider #: _____

Date: _____

Payment Reporting and Publication Email Preferences

All applicants must complete

Provider Claim Report (PCR) Information

The following information will allow the Medical Assistance Program to prepare your PCR in a manner that is helpful for you. Please indicate your preferences.

☐ My claims will be submitted by (through) another provider who will receive the PCRs and payments. (Skip remaining Provider Claim Report questions - **No start-up Billing Packet will be sent**.)

Sort sequence preference

In what order do you want claims listed on the PCR? If no selection is made, claims will be sorted in order by client last name.

☐ Client last name (N)
☐ Date of Service (D)
☐ Client State Medical Assistance Program ID (I)
☐ Patient account/Invoice number (A)
☐ Rendering Provider Number (B) (may be useful for group practices)
☐ Rendering Provider Name (P) (may be useful for group practices)

Reporting in process (suspended) claims

How do you want in-process (suspended) claims reported on the PCR? If no selection is made all suspended claims will be listed.

☐ List all suspended claims (A)
☐ List only new suspended claim (O)
☐ Do not list suspended claims (N) (not recommended)

Publication Email Notification Preference

The Colorado Medical Assistance Program communicates important notices (including time-sensitive information), updates, billing instructions and bulletin links via email as soon as the information is available. *Providers are responsible for ensuring that the fiscal agent has their current email address on file. The Colorado Medical Assistance Program is not responsible for undeliverable notifications due to incorrect email addresses.*

All publications are available in the Provider Services section of the Department's Web site at colorado.gov/hcpf.

Publication Email Notification Preference *(Please check one)**:***

☐ Please email notifications and bulletin links to me.

☐ Another provider will receive email notifications and bulletin links on my behalf. *(I understand that I am responsible for obtaining the information from this provider and that I will **not** receive any email notifications from the Colorado Medical Assistance Program)*.

☐ None *(I understand that I am responsible for retrieving publications from the Web site and that I will **not** receive any email notifications from the Colorado Medical Assistance Program).*

Provider Publications E-mail Address: _____

*Please note that only **one** email address per provider may be on file.*

Please return the completed Provider EDI Enrollment Application to the following address:

ACS State Healthcare
Colorado Medical Assistance Program
Provider Services
P.O. Box 1100
Denver, CO 80201-1100