Print Form

COLORADO

MEDICAL ASSISTANCE PROGRAM

RENDERING PROVIDER APPLICATION

Individual group-affiliated providers who complete this application cannot directly bill the Colorado Medical Assistance Program and will not receive direct reimbursement.

Fiscal Agent for the
Colorado Medical Assistance Program

ACS
A xerox Company

PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757 or -800-237-0044

colorado.gov/hcpf

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Individual Name and Social Security Information

All applicants must complete

1 Name and Social Security Number

Individuals

Individual practitioners must enroll using the name shown on their social security card. If payments for services are to be made to a group practice, partnership, or corporation, then the group, partnership, or corporation must enroll and obtain a Colorado Medical Assistance Program provider number to be used for submitting claims as the billing provider. All individual practitioners who render services must be enrolled.

Individuals Last Name	First Name	M.I.	Title/Degree	Social Security Number

Please check if you have seen Colorado Medical Assistance clients within the past 120 days ☐

Contact Information

If there are questions concerning this application, who may be contacted if the person submitting the application is not the applicant?

Contact Name: _____

Contact Phone Number and/or Email Address: _____

This space for fiscal agent use

Provider Address Information

All applicants must complete

2 Service Location Address & Phone Information

All applicants must complete. Provide the street address of the location where services will be rendered.

Street address (must be street address)

City | County | State | Zip

( ) Voice Telephone number

( ) Fax Telephone number

3 Billing Office Address & Phone Information

Click Here if Same As Service Location

Complete the following information if the billing office address is different from service location address. Payments (if any) made under the assigned provider number will be sent to this address if different from the service location address.

Street address, PO Box

City | County | State | Zip

( ) Voice Telephone number

( ) Fax Telephone number

Business e-mail address:

4 Mailing Address & Phone Information

Click Here if Same As Service Location

Complete the following information if the mailing office address is different from service location and billing addresses. Special mailings (if any) made under the assigned provider number will be sent to this address if different from the service location and billing addresses.

Street address, PO Box

City | County | State | Zip

( ) Voice Telephone number

( ) Fax Telephone number

Click Here if Same As Billing Office

Business e-mail address:

5 Faxback Eligibility Telephone Number

Faxback eligibility allows providers to verify eligibility by telephone and, after hearing the information spoken, receive a fax of the information. If you wish to use this service, your fax telephone number must be recorded on your provider enrollment record. Please identify the telephone number where the faxback eligibility report should be sent. Only a single faxback number can be recorded.

Faxback telephone number ( )

Provider Type, Licensure, and Specialty Information

All applicants must complete

6 Provider Type

All applicants must complete. From the list below, identify the provider type (refer to the provider type listing in Appendix A) appropriate to this application. You must complete a separate application for each provider type (check only one box). If you do not find the appropriate provider type on the list below, you may not be eligible to enroll in the Medical Assistance Program at this time. Please call the Medical Assistance Program Provider Services at 1-800-237-0757 for assistance and further directions.

Audiologist (19) ☐
- Deaf and Hard of Hearing ☐

Dental
- Dentist (04) ☐
- Orthodontist (04), Specialty (63) ☐
- Dental Hygienist (04), Specialty (66) ☐

Nurse Anesthetist, CRNA (40) ☐

Nurse Midwife (22) ☐

Nurse Practitioner (41) ☐

Nurse, Registered (24) ☐

Optometrist (07) ☐

Physician Assistant (39) ☐

Physician
- M.D. (05) ☐
- D.O. (26) ☐

Podiatrist (06) ☐

Psychologist PhD Level (37) ☐

Psychologist MA Level (38) ☐
(LCSW, LMFT and LPC)

TRCCF
- M.D. (05) ☐
- D.O. (26) ☐
- Psychologist, PhD Level (37) ☐
- Licensed Mental Health Practitioner (38) ☐

Therapist
- Occupational (28) ☐
- Physical (17) ☐
- Speech (27) ☐

7 Licensure

Complete if applicable. Provider types requiring license information are identified in Appendix A. Attach a copy of license(s). Please include copies that contain the original effective date and expiration date.

License No.	License authority /board

Provider Type, Licensure, and Specialty Information - Continued

All applicants must complete

8 Practitioner Specialty Information

All practitioners please complete. If board certified, please provide the specialty board certification number, effective date, *and expiration* of certification. If needed, provide additional information on the reverse or attach additional pages.

Specialty	Certificate Number	Effective	Expiration

Provider Certification and Registration Information

All applicants must complete

9 Malpractice/ General Liability Information

Malpractice/General liability insurance is mandatory under current State and Federal laws

Medical Malpractice/General Liability Insurance Carrier: _____

10 Other Registration Information

Applicants with a Taxonomy Number (UPIN), Drug Enforcement Agency number, or National Provider Identification number must complete. Provide the requested information below.

	Number	Begin Date	End Date
Taxonomy Number ➡			
DEA Number ➡			
NPI Number ➡			

11 CLIA Registration Information

Applicants who provide laboratory testing services must complete. Enter your *current* CLIA registration number(s). If you do not perform CLIA office testing, you may omit this section. Attach a photocopy of your CLIA certificate that indicates the effective date and the expiration date. (Attach additional pages if necessary.) Note that this information is for CLIA certificates that you **hold**, not for laboratories, etc. that you **use**.

CLIA Number	Certification Type	Effective Date	Expiration Date

Provider Disclosures

All applicants must complete

12	Individuals	Please enter your name	_____
		Please enter any alias name(s) used	_____
			_____
		Have you been convicted of a criminal offense?*	☐ Yes ☐ No
		If yes, please explain: (Attach additional sheets if needed)	_____

*related to Medicare, Medical Assistance Program or Title XX services program since the inception of those programs.

Affiliation Information – Group and Clinic Members

Individual practitioner applicants who will submit claims through a group or clinic must complete.

This includes individual physicians working in IHS clinics.

Please identify each affiliation by name and Colorado Medical Assistance Program Provider number. Individual providers cannot bill using a group number that is not listed below. Providers are required to notify the Colorado Medical Assistance Program Provider Enrollment in writing of any change in affiliation information.

	Name	Medical Assistance Program Provider #
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

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) (Indicate 'Pending' for new enrollment or provider number if previously enrolled)

("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.

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 Colorado 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, understands 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 on the Department's Web site at colorado.gov/hcpf ➡Providers ➡Provider Services ➡Specifications.

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

PROVIDER REPRESENTATIVES CANNOT COMPLETE THIS PAGE ON BEHALF OF THE PROVIDER THE APPLYING PROVIDER MUST PERSONALLY COMPLETE 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 Signature

Name: _____
Provider Name (please print)

Date: _____

Please return the completed Provider Enrollment Form, Provider Authorization Form (if applicable), and executed Provider Participation Agreement to the following address:

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

Practitioners and Practitioner Groups

The Internal Revenue Service requires that payments made to an individual be reported to the individual's social security number. All individual practitioners must be enrolled.

If an enrolled individual wants payments made to a corporation, partnership or sole proprietorship (group), the group must be enrolled and have a group provider number. The group provider number must be identified as the billing provider on all claims.

Services/Providers	Licensure & certification submission requirements
Certified Nurse-Midwife (22)	Attach state nursing license and certificate from American College of Nurse-Midwives.
Clinic, Professional Corporation, Partnership, or Sole Proprietorship (16)	At least one Colorado Medical Assistance Program-enrolled practitioner must be listed. Requires CLIA certificate for laboratory services if applicable.
Optometrist (07)	Attach state optometry license.
Physician (MD) (05) and (DO) (26)	Attach state medical license and specialty certification if applicable. Requires CLIA certificate for laboratory services if applicable.
Podiatrist (06)	Attach state podiatry license. Requires CLIA certificate for laboratory services if applicable.
Non-Physician Practitioner Group (25)	At least one Medical Assistance Program-enrolled non-physician practitioner must be listed.

Non-Physician Practitioners - Requiring on-premise physician supervision

Requires on-premise physician supervision when services are provided and payments must be made to a physician or clinic. Must identify physician supervisor by name on the separate "Non-Physician practitioners requiring on-premise physician supervision" form.

Services/Providers	Licensure & certification submission requirements
Registered Nurse (24)	Attach state nursing license.

Non-physician Practitioners - Special direct payment requirements

For direct payment, must complete a Standard Provider Application and sign the statement certifying that services are not provided in the course of employment otherwise payments must be made to a physician or clinic.

Services/Providers	Licensure & certification submission requirements
Audiologist (19)	Attach copy of Colorado Audiology License Certification from the American Speech and Health Association or the American Board of Audiology. Proof of registration with State Audiology and Hearing Aid Provider Registration Office. If providing services in the course of employment, payments must be made to a physician or clinic.
Certified Registered Nurse Anesthetist (40)	Attach state nursing license and certification by the Council on Nurse Anesthetists. If providing services in the course of employment, payments must be made to a physician or clinic.
Doctorate Level Psychologist (37)	Licensed: Attach Colorado Psychologist License. Unlicensed: Cannot enroll.
Licensed Mental Health Professional (under Doctorate Level) (38)	Attach state social work license or professional counselor license and proof of education. If providing services in the course of employment, payments must be made to a physician or clinic.

Non-Physician Practitioners - Special direct payment requirements

For direct payment, must complete a Standard Provider Application and sign the statement certifying that services are not provided in the course of employment otherwise payments must be made to a physician or clinic.

Services/Providers	Licensure & certification submission requirements
Nurse Practitioner (41)	Attach State Nursing License + one of the following: Pediatric Nurse Practitioner Certificate from National Certification Board of Pediatric Nurse Practitioners or Family Nurse Practitioner Certificate from American Nurse Association. If providing services in the course of employment, payments must be made to a physician or clinic.
Occupational Therapist (28)	Attach state occupational therapy license. If providing services in the course of employment, payments must be made to a physician or clinic.
Physical Therapist (17)	Attach State physical therapy license. If providing services outside the course of employment only general physician supervision is required. If providing services in the course of employment, payments must be made to a physician or clinic.
Physician Assistant (39)	Attach state medical license. If providing services outside the course of employment only general physician supervision is required. If providing services in the course of employment, payments must be made to a physician or clinic.
Speech Therapist (27)	Attach American Speech and Hearing Association certification. If providing services in the course of employment, payments must be made to a physician or clinic.

Dental providers and dental groups

The Internal Revenue Service requires that payments made to an individual be reported to the individual's social security number. All individual dental providers must be enrolled.

If an enrolled individual wants payments made to a corporation, partnership or sole proprietorship (group), the group must be enrolled and have a group provider number. All claims must identify the group provider number as the billing provider on all claims.

Services/Providers	Licensure & certification submission requirements
Dental Clinic, Professional Corporation, Partnership, or Sole Proprietorship (47)	Dental clinic ownership must be a licensed dentist or dental hygienist, a political subdivision, or a non-profit corporation. In state dental clinic owners must have a current/active/valid Colorado dental or dental hygienist license. Attach a copy of the license. A non-profit corporation must be in good standing and submit a copy of the Certification of Good Standing issued by the Colorado Secretary of State. At least one Medical Assistance Program enrolled dentist or dental hygienist must be associated with the clinic. Attach a copy of the dental license.
Dentist (04)	Attach a copy of state dental license.
Orthodontist (04), Specialty (63)	Attach a copy of state dental license and certificate of graduation from an American Dental Association Accreditation Commission accredited program in orthodontics.

Dental providers with special direct payment requirements

Licensed dental hygienists shall be directly reimbursed for unsupervised dental hygiene services rendered to Medical Assistance Program enrolled children effective February 1, 2002. Those licensed dental hygienists requesting direct reimbursement must complete a provider enrollment form. The dental hygienist employed by a dentist, clinic or institution shall not submit claims individually and shall submit claims under the employer's assigned Medical Assistance Program provider number.

Dental Hygienist (04), Specialty (66) Attach a copy of state dental hygiene license

Non-physician practitioners requiring on-premise physician supervision

Applicants listed below who, by state regulation, require on-premise physician supervision, must complete

- Registered Nurses (Other than employees of a Certified Health Department**)

The provider types listed below must complete the appropriate form for their provider type. These forms are also available for download in the Provider Enrollment section. By enrolling for direct payment, you are certifying that services are not provided in the course of employment.

• Audiologists	• Occupational Therapists
• Certified Registered Nurse Anesthetists	• Physical Therapists
• Masters' Level Mental Health Professionals	• Physician Assistants
• Nurse Practitioners	• Speech Therapists and Speech Pathologists

Benefit services by non-physician practitioners must be provided in compliance with the following requirements:

- Services must be performed under the direct and personal supervision of an on-premise physician who is immediately available when services are provided. This means that the supervising physician must be physically present on the premises when the service is provided.
- Services must be ordered by the supervising physician.
- Claims must be submitted through the supervising physician. The non-physician practitioner must look to the supervising or billing provider for compensation.
- The supervising physician's Colorado Medical Assistance Program provider number must appear on the claim form as the supervising physician, the referring physician, or the billing provider.
- Claims must be billed using procedure codes specifically designated for non-physician billing.
- Claims must identify the non-physician practitioner by provider number as the rendering provider.
- The non-physician practitioner applicant must identify the Colorado Medical Assistance Program enrolled physician(s) who will provide on-premise supervision. The supervisor's original signature must be included on the application. An original signature assures that the supervisor is aware of and understands the supervisory role and requirements.

** Employees of a certified Health Agency do not require on premise supervision. Complete this form by identifying the Agency's physician by name and provider number and write "Certified Health Agency" on line one in the space for the physician's signature.

	Supervising Physician Name	Colorado Medical Assistance Program Provider #	Supervising Physician's Original Signature
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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