Load Letter Request (LLR)

DO NOT ALTER THIS FORM

The Department will accept LLR on this form only. Your request will be processed within 10 business days. NOTE: Please write legibly. Forms missing information will be sent back to the requestor which will cause a delay in the request. If you have any questions, please contact Renee Robinson at 303-866-5622.

Note: If the dates of service are within 365 days from the date of the request you will not be issued a LL. You will be advised to use the Late Bill Override Process (LBOD). Please refer to the LBOD instructions located in the Provider Services Billing Manuals section of the Department's Web site.

Today's Date: _____

Client Information:

State Medicaid ID: _____ DOB: _____ SSN:_____

Last Name: _____ First Name: _____

Dates of Service to be covered with the Request: _____

(*For Department Use Only: Please leave this section blank)

**County of Residence*_____

Medicaid Verification of Eligibility Date*_____Case number*_____

Return Completed Load Letter to:

Provider Name: _____Provider Medicaid ID: _____

Name of Contact: _____ E-mail_____

Phone Number: _____FAX NUMBER:_____

DO NOT Check this box ☐ **unless** you represent a Behavioral Health Organization (BHO).

Email to: loadletterrequests@hcpf.state.co.us

Note: If sent via email, this form MUST be encrypted. To encrypt your completed form:

1. In Microsoft Word, select the Tools option from the menu bar.
2. Select Options... from the drop down menu.
3. Click on the Security tab and enter "hcpf" in the Password to open: field located in the File encryption options for this document section.
4. Click OK.

If you are unable to encrypt the form, you may also fax your request to (no cover sheet or attachments please): **303-866-2082**

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