ACCOUNTABLE CARE COLLABORATIVE (ACC) PROGRAM
PRIMARY CARE MEDICAL PROVIDER (PCMP) CONTRACT

CONTRACT COMPLETION INSTRUCTIONS

Please read the following instructions carefully. Incomplete or incorrect contract documents will delay the process of contract execution.

We require three signed copies of the contract, PCMP Provider ID information sheet, and a W-9 in order to process the contract. The information sheet must list all Medicaid Billing IDs that the contract will cover (all IDs for the practice).

INSTRUCTIONS FOR FILLING OUT CONTRACT:

1. **Page 1 - TITLE**: Insert the exact FULL LEGAL NAME of the Provider. This name should be the exact same name found on your W-9 and should match the Provider's legal name as listed on the Provider's Federal 147C Letter and the Secretary of State website.

2. **Page 1, Section 1 – PARTIES**: Insert the exact same FULL LEGAL NAME of the Provider and the Provider's address. This name must be **exactly** the same as the name entered in the TITLE on the top of Page 1. The Address **must be a physical address** and cannot be a PO Box.
   Example: Partners for Care, LLC, located at 1111 Main Street, Anywhere, Colorado 80000

3. **Page 9, Section 16 – NOTICES AND REPRESENTATIVES: (For the Contractor)**

   List the individual who is the designated representative for the Provider, responsible for receipt and delivery of all contract notices. Insert the following four items:

   a. Designated representative's name
   b. Designated representative's title
   c. Designated representative's full mailing address
   d. Designated representative's E-mail address

4. **Page 16, CONTRACT EXECUTION SIGNATURE PAGE:**

   Legal Name of Contracting Entity: Insert the exact FULL LEGAL NAME of the Provider as used on Page 1 in TITLE and SECTION 1.

   Name, Title and Date of Authorized Officer Signature: Print the full name and title of the person signing the Contract. Be sure to include the date of signature.
   Signature of Authorized Officer: The person signing the contract must have legal authority to bind the Provider. If the person signing does not have apparent authority, then the State may request documentation of authority to legally bind the Provider. **An original signature is required on both originals of the contract.**

Please note that a tracking number will be filled in by the State on the top right corner of the first page. Please leave this blank. When executed by the State, an orginal contract will be provided to the Provider.

***** Revisions to the terms and conditions of the PCMP Contract will not be considered. *****

RETURN THE FOLLOWING DOCUMENTS TO THE STATE:

1. **THREE ORIGINAL SIGNED CONTRACTS.**

   You must return **three (3) original signed contracts**. Faxes, electronic scans, or copies will not be accepted. Mail the original signed contracts to the Department at the following address:

   Marceil Case
   Department of Health Care Policy and Financing
   1570 Grant Street
   Denver, CO 80203

2. Enclose a copy of your W-9 with your three (3) orginal signed contracts.

3. PCMP Provider ID (Practice) Information form.

IMPORTANT NOTICE

Providers are reminded that a change of ownership or a change of tax ID number terminates the Medical Assistance Program Provider participation agreement. New owners and providers with new tax ID numbers must re-apply and complete a new Medical Assistance Program Provider Participation Agreement in order to participate in the Colorado Medical Assistance Program. In such circumstances a new PCMP contract will also be required.