Primary Care Physician Application

Colorado Department of Health Care Policy & Financing

Date of Application: _____

Please complete the entire application and sign on page 4.
Mail the *completed* Application and all supporting documentation to:

The Colorado Medical Assistance Program
Provider Enrollment
Post Office Box 1100
Denver, Colorado 80201-0090

For Official Use Only

Date Application Received: _____ Application Complete: ☐ Yes ☐ No

_____ _____

Application pending additional information needed: _____

Reviewed by:

_____
Medical Assistance Program Fiscal Agent

PCP ENROLLMENT

Are you a first time PCP applicant? ☐ Yes ☐ No **Re-enrolling PCP applicant?** ☐ Yes ☐ No

Please indicate the provider number to which Medical Assistance Program payment should be made (i.e., individual or group #):

☐ **Individual #:** _____ **or** ☐ **Group #:** _____

Are you fluent in any languages other than English, including American Sign Language? ☐ Yes ☐ No

If yes, please list: _____

SECTION I: INDIVIDUAL PHYSICIAN BACKGROUND INFORMATION

Name: _____ ☐ **MD** ☐ **DO** **Date of Birth:** ___/___/___
(Last, First, MI)

Colorado Board of Medical Examiners License Number: _____ Expiration Date: ___/___/___

DEA Number: _____

CLIA Number: _____

Effective Date: ___/___/___ Expiration Date: ___/___/___

Medical Assistance Program Individual Provider Number: _____ **Social Security #:** _____

Medicare Certification: ☐ Yes ☐ No **UPIN:** _____ **Medicare Number:** _____

Board Certification(s): ☐ Yes ☐ No If yes, please indicate specialties:

1. _____
2. _____
3. _____

Medical Malpractice Insurance Carrier: _____
(Must comply with current Federal and State regulations)

SECTION II: PRACTICE INFORMATION

DBA Name: _____
(Indicate Doing Business As (DBA) Group Practice name, if different from name)

Group #: _____ **Tax ID #:** _____

Type of Practice: ***Check only one*** ☐ Individual ☐ Group
☐ Rural Health Clinic ☐ Federally Qualified Health Center ☐ Indian Health Clinic

Primary Office Address: _____ City: _____

Zip+4 Code: _____ County: _____ Counties served: _____

Office Telephone: _____ Fax: _____

E-mail: _____ Office Hours: _____

Second Office Address: _____ City: _____

Zip+4 Code: _____ County: _____ Counties served: _____

Office Telephone: _____ Fax: _____

E-mail: _____ Office Hours: _____

Percentage of your practice that are Medical Assistance Program clients? _____ % (Best Estimate)

Are you currently willing to accept additional Medical Assistance Program clients? ☐ Yes ☐ No If yes, how many? _____

Professional Staffing:

Residents: ☐ Yes ☐ No If yes, how many? _____

Non-Physician Professionals: ☐ Yes ☐ No If yes, please indicate the number of each of the following:

Nurse Practitioners: _____ Physician Assistants: _____

Clinical Nurse Specialists: _____ Certified Nurse Midwives: _____

SECTION III: ACCREDITED AFFILIATIONS

This section is used by the Department of Health Care Policy and Financing for credentialing verification.

A. Hospital affiliations

1. Name of Hospital: _____
   City: _____ County: _____
2. Name of Hospital: _____
   City: _____ County: _____

If no privileges, please describe your hospital admission protocol: _____

_____

_____

B. List all Managed Care Organizations affiliations:

1. _____
2. _____
3. _____
4. _____

SECTION IV: PRIMARY CARE PHYSICIAN CASE MANAGEMENT CERTIFICATION

I, _____ , hereby certify that:
Print name

1. The preceding Primary Care Physician information is accurate and completely represents my current certification and practice.
2. I am able to perform the essential duties of the Primary Care Physician as stated in the PCP contract.
3. I am not currently using or dependent on any illegal or addictive substances.

SECTION V: TERMS OF APPLICATION

The following ***required information*** must be attached to this application. Failure to provide this information makes this application null and void.

1. Five-year claims liability history or statement that there is no claims liability history.
2. Copy of your curriculum vitae for the last five calendar years. Please include medical education, training, work history and describe any gaps

This Application supplements your current Colorado Medical Assistance Program Primary Care Physicians Contract and Medical Assistance Program Provider Enrollment Application and will be enforced in conjunction therein. A breach of any is a breach of all.

I, _____ (Print name and title)

certify that all preceding information is correct and complete. I acknowledge that failure to provide true and accurate information is grounds for termination from the Primary Care Physician Program and possible recoveries of payment with penalties.

NOTICE TO APPLICANT: Your submission of this application constitutes an offer. Acceptance of this offer results in a binding agreement effective upon approval of your application. The terms of the agreement include your application, the Primary Care Physician Contract and the Medical Assistance Program Provider Enrollment Application.

As a physician in the Primary Care Physician Program, you agree that the Department of Health Care Policy and Financing may execute this agreement by electronic signature, which will constitute an original of this application and be enforceable as if manually signed by the State.

_____ _____
Signature Date