Print Form

THE COLORADO MEDICAL ASSISTANCE PROGRAM

Provider Services
P.O. Box 1100
Denver, CO 80201-1100

1-800-237-0757

PROVIDER ENROLLMENT UPDATE FORM

Almost all of the updates available on this form can be made through the Colorado Medical Assistance Program Web Portal (Web Portal)

Only one provider may be updated per form. Please complete all applicable information, sign and date this form (page 2), and send to the address indicated above. Please allow 10 calendar days from date of mailing to process your updates.

Date*: _____ / _____ / _____ Medical Assistance Program Provider Number*: _____

Provider Name*: _____ Tax ID (EIN or SSN)*: _____

DEMOGRAPHICS – Update your address(es) (May indicate "Same" if updating multiple addresses, at least one must be completed)

☐ Billing – Used for payments	☐ Location – May require state approval	☐ Mail-To – Used for correspondence
Street	Street	Street
City	City	City
State Zip	State Zip	State Zip
Phone Number	Phone Number	Phone Number
Fax Number	Fax Number	Fax Number

– Enrollment backdating is not available through the Web Portal –

BACKDATE ENROLLMENT – Request an effective date prior to the current enrollment effective date

☐ Please backdate my enrollment effective date to: _____ / _____ / _____ (Please use a 4-digit year)

Please attach rationale for being backdated to the requested date.
Requests for over 120 days from the current effective date will require state approval.

NATIONAL PROVIDER IDENTIFIER (NPI) – Provide your NPI(s) (attach additional sheets if needed)

Number: _____ Taxonomy: _____ Effective Date: _____ / _____ / _____

Number: _____ Taxonomy: _____ Effective Date: _____ / _____ / _____

LICENSURE – Provide documentation for the license being updated

Number: _____ Effective Date: _____ / _____ / _____ Exp Date: _____ / _____ / _____

Documentation: ☐ Copy of Updated License ☐ DORA Licensure Verification Printout
Only applicable to provider types licensed by DORA

PUBLICATION PREFERENCE – Change notification method and update your email address

☐ Update my email address Email: _____

*Indicates required fields for all update requests

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ADD AFFILIATION(S) – Add affiliation(s) to your provider file (attach additional sheets if needed)

Provider ID: _____ Name: _____ Eff. Date: ___/___/___

Provider ID: _____ Name: _____ Eff. Date: ___/___/___

Provider ID: _____ Name: _____ Eff. Date: ___/___/___

Provider ID: _____ Name: _____ Eff. Date: ___/___/___

Provider ID: _____ Name: _____ Eff. Date: ___/___/___

REMOVE AFFILIATION(S) – Remove affiliation(s) from your provider file (attach additional sheets if needed)

Provider ID: _____ Name: _____ End Date: ___/___/___

Provider ID: _____ Name: _____ End Date: ___/___/___

Provider ID: _____ Name: _____ End Date: ___/___/___

Provider ID: _____ Name: _____ End Date: ___/___/___

Provider ID: _____ Name: _____ End Date: ___/___/___

– Enrollment termination is not available through the Web Portal –

TERMINATE ENROLLMENT – Please indicate the reason(s) for termination and effective date

Dissatisfied with the:

- ☐ Department of Health Care Policy & Financing
- ☐ Fiscal Agent (Xerox State Healthcare)
- ☐ Prior Authorization Process
- ☐ Reimbursement Rates

Provider is Not Dissatisfied, I am/we are:

- ☐ Changing Ownership and not Re-Enrolling
- ☐ Leaving the Medical Field
- ☐ Moving Out of State
- ☐ Other Reason(s) (please indicate):

Effective Date: ___/___/___ Comments: _____
Attach additional sheets if needed

May we contact you for further follow-up regarding your termination? ☐ Yes ☐ No

Contact Person: _____ Phone #: _____

CERTIFICATION STATEMENT – Please read the following, sign, and date

I certify by my signature below that I am fully authorized to sign and execute this Enrollment Update on behalf of the aforementioned provider. I understand that any information requested and provided on this form does not change or alter the terms of my executed 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.

Name*: _____ Title*: _____

Signature*: _____ Date*: ___/___/___

An authorized agent must sign if you are a group provider or the actual provider must sign if you are an individual provider.
Unsigned forms will not be processed and will be returned.

*Indicates required fields for all update requests