THE COLORADO MEDICAL ASSISTANCE PROGRAM

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

1-800-237-0757
Fax: 303-534-0439

Provider Enrollment Application Check List and Instructions for a

Hospice

(Standard Provider Application for Direct Pay Enrollment.)

Provides palliative/comfort care for patients with a terminal illness defined as a prognosis of life expectancy of 6 months of less. Services consist of nursing, certified nurse aide, physical therapy, counseling, or trained volunteers, and bereavement services.

The documents listed below are required and must be submitted with the application.

☐	**Completed Electronic Funds Transfer (EFT) Form** – The legal business name on this form must match exactly with the name on file with the IRS. The address on this form must match one of the addresses listed in the application. This form must be completed using the employer identification number assigned to the business.
☐	**Completed W-9 Form** – The legal business name on this form must match exactly with the name on file with the IRS. The address on this form must match one of the addresses listed in the application. This form must be completed using the employer identification number assigned to the business.
☐	**License-** Attach a copy of the license from the Department of Public Health and Environment.
☐	**Medicare Certification** – Attach a copy of the Medicare Approval/Certification Letter.
☐	**Completed Provider Disclosures Page (Section 19 of the Application) –** The 'Legal Name & Business Category' area must be completed in its entirety. Please list those who have an ownership interest equal to, or more than five percent, or list the officers, directors, and partners of the disclosing entity and their relationship to each other. Entering N/A is not acceptable and will require resubmission of the completed area prior to approval.