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 Checklist and Instructions for a

Rural Health Clinic

(Standard Provider Application for Direct Pay Enrollment.)

A rural clinic funded through federal government grants to help maintain public health.

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.
☐	**Medicare Certification** – Attach a copy of the Medicare Approval/Certification Letter (indicating freestanding) and the Medicare rate sheet.
☐	**Completed Affiliation Information (Page 12) -** Must list all the rendering individuals the clinic will submit claims for.
☐	**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.
☐	**Other** – Attach a copy of the provider's cost report.