COLORADO MEDICAL ASSISTANCE PROGRAM

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

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

Colorado Medicaid Provider Claim Report Opt-Out Form

Providers who no longer want to receive the Proprietary Colorado Medicaid Paper Claim Remittance Advices.

To discontinue the Paper Claim Remittances, a provider must meet the following criteria:

- ☐ **It's been 31 calendar days since the successful Implementation of v5010 X12 835 transaction report.**
- ☐ **Three payments have been received from Colorado Medicaid within 31 calendar days.**

Please remember this is completely an option to no longer receive Paper Claim Remittances from Colorado Medicaid.

PROVIDER LEGAL NAME: _____

PROVIDER DBA NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MEDICAID PROVIDER #: _____ PHONE NUMBER: _____

_____ _____

Authorized Signature Date

Return the completed form to:

The Colorado Medical Assistance Program
Provider Enrollment
P.O. Box 1100
Denver, CO 80201-1100