Health First Colorado (Colorado’s Medicaid program) & CHP+ Network Participation Verification

This form serves to confirm participation of a Health First Colorado or Child Health Plan Plus (CHP+) provider in a Managed Care Organization (MCO) or Regional Accountable Entity (RAE) that is contracted with the Department of Health Care Policy and Financing (HCPF). This verification is required when a provider enrolls as a new Health First Colorado or CHP+ provider, or when a current provider updates Health First Colorado or CHP+ network participation. Note: Verification of RAE participation is required only for RAE contracted behavioral health providers.

Instructions: Complete this form and upload it as an attachment on the Attachments and Fees page of the Online Provider Enrollment tool.

Please select the program(s) in which the provider participates as a network provider:

- [ ] ASOD – DentaQuest USA Insurance
- [ ] CHP+ - Colorado Access
- [ ] CHP+ - DentaQuest USA
- [ ] CHP+ - Denver Health Medical Plan Inc.
- [ ] CHP+ - Friday Health Plans
- [ ] CHP+ - Kaiser Permanente
- [ ] CHP+ - Rocky Mountain HMO Inc.
- [ ] CHP+ - State Managed Care Network
- [ ] MCO – Denver Health Medical Choice
- [ ] MCO – Rocky Mountain Health Plans Prime
- [ ] MCO – Total Longterm Care Pueblo (PACE)
- [ ] MCO – TRU Community Care (PACE)
- [ ] PACE – InnovAge/Total Longterm Care Aurora
- [ ] PACE – InnovAge/Total Longterm Care Denver
- [ ] PACE – InnovAge/Total Longterm Care Lakewood
- [ ] PACE – InnovAge/Total Longterm Care Loveland
- [ ] PACE – InnovAge/Total Longterm Care Thornton
- [ ] PACE – Rocky Mountain Health Care Services
- [ ] PACE – Senior Community Care
- [ ] RAE (Region 1) Rocky Mountain Health Plans
- [ ] RAE (Region 2) Northeast Health Partners
- [ ] RAE (Region 3) Colorado Access
- [ ] RAE (Region 4) Health Colorado, Inc.
- [ ] RAE (Region 5) Colorado Access
- [ ] RAE (Region 6) Colorado Community Health Alliance
- [ ] RAE (Region 7) Colorado Community Health Alliance
- [ ] RAE (Region 8) Denver Health Medical Plan

Provider Information

Provider Legal Name (group or individual): ____________________________________________

Provider DBA Name (if applicable): __________________________________________________

NPI #: ____________________ NPI Zip Code +4: _______________ Medicaid ID (if applicable)*: ____________

*IIf new provider, state “pending”

I attest that this information is true:

Provider Printed/Typed Name: ________________________________________________________

Provider/Attester Signature: __________________________________ Date: ________________

If you have any questions about the use of this form, please contact your MCO/RAE provider relations representative.