



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, when a current provider updates Health First Colorado or CHP+ network participation, and when a provider completes the Health First Colorado and CHP+ provider revalidation process. **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:

- | | |
|--|---|
| <input type="checkbox"/> RAE (Region 1) Rocky Mountain Health Plans | <input type="checkbox"/> MCO Colorado Access (CHP+) |
| <input type="checkbox"/> RAE (Region 2) Northeast Health Partners | <input type="checkbox"/> MCO Delta Dental Plan of CO (CHP+) |
| <input type="checkbox"/> RAE (Region 3) Colorado Access | <input type="checkbox"/> MCO Denver Health Medical Plan Inc. (CHP+) |
| <input type="checkbox"/> RAE (Region 4) Health Colorado, Inc. | <input type="checkbox"/> MCO Friday Health Plans (CHP+) |
| <input type="checkbox"/> RAE (Region 5) Colorado Access | <input type="checkbox"/> MCO Kaiser Permanente (CHP+) |
| <input type="checkbox"/> RAE (Region 6) Colorado Community Health Alliance | <input type="checkbox"/> MCO Rocky Mountain HMO Inc. (CHP+) |
| <input type="checkbox"/> RAE (Region 7) Colorado Community Health Alliance | <input type="checkbox"/> MCO InnovAge/Total Longterm Care (PACE) |
| <input type="checkbox"/> MCO Denver Health Medicaid Choice | <input type="checkbox"/> MCO Rocky Mountain Health Care Services (PACE) |
| <input type="checkbox"/> MCO Rocky Mountain Health Plans PRIME | <input type="checkbox"/> MCO Senior Community Care (PACE) |
| | <input type="checkbox"/> MCO TRU Community Care (PACE) |

Provider Information

Provider Legal Name (group or individual): _____

Provider DBA Name (if applicable): _____

NPI #: _____ NPI Zip Code +4: _____ Medicaid ID (if applicable)*: _____

**If 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.