



Colorado Medical Assistance Program

DSH EDI UPDATE FORM

Current DSH EDI Trading Partner ID: _____

DSH EDI Submitters may change/update the following sections of the DSH Electronic Data Interchange (EDI) Submitter Enrollment & Agreement

I no longer want my clearinghouse/switch vendor/billing agent to retrieve my reports.
I want to retrieve my own reports.

Section 1. Classification

Software Vendor Clearinghouse / Switch Vendor

Section 2. Submission method

Please indicate how you plan to submit your electronic transactions.

State's Provider Web Portal

Submitters changing their submission method from:

The State's Provider Web Portal **to** a Clearinghouse/Switch Vendor
Must complete and submit the PROVIDER AUTHORIZATION FORM included with this form.
(Each provider must complete an Authorization Form)

Submitters changing their submission method from:

A Clearinghouse/Switch Vendor **to** the State's Provider Web Portal
Do not need to complete and submit the PROVIDER AUTHORIZATION FORM (page 4) with this form.

Section 3. DSH EDI Trading Partner/Submitter Information

Legal Name: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____



Colorado Medical Assistance Program

Section 4. Contact Information

Sub-Section 4a. Primary Contact Information

Contact Individual Name: _____ Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____

Sub-Section 4b. Secondary Contact Information

Contact Individual Name: _____ Contact Title: _____

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Email Address: _____

Section 5 Software Vendors Only

Software Product Name: _____ Software Version: _____

Section 6. Transactions Available for Transmission



X12N 270 (Eligibility Inquiry)



Colorado Medical Assistance Program

HOSPITAL PROVIDER AUTHORIZATION FORM

Must be completed for each Authorizing Hospital Medicaid provider number

This authorization must be completed and signed by the billing provider who wishes to authorize a billing agent, clearinghouse, or other provider to maintain, control, submit and/or retrieve designated reports/transactions.

The billing agent, clearinghouse, or other provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.

Provider, _____ hereby appoints
Provider Name (please print)

Billing Agent/Clearinghouse/Other Provider Name (please print)

Billing Agent/Clearinghouse/Other Provider Trading Partner or Submitter
ID

to act as an authorized agent for the purpose of **submitting** health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program.

Provider must also check one box below:

Provider authorizes the agent listed above to **retrieve** some or all electronic reports/responses on Provider's behalf

OR

Provider does NOT authorize the agent listed above to **retrieve** electronic reports/responses on Provider's behalf.

Provider/Provider Representative Name (please print)

Provider/Provider Representative Signature

Date

Provider Number

This Authorization may be modified or revoked at any time in writing.
It is considered in effect until modified or revoked.



COLORADO

Department of Health Care
Policy & Financing

Colorado Medical Assistance Program

Please return the completed DSH EDI Update Form,
Provider Authorization Form (if applicable), to the
following address:

**DSH EDI Enrollment
Colorado Medical Assistance Program
DSH EDI Submitter Services
P.O. Box 1100
Denver, CO 80201-1100**