



# 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.

Return completed form (or revocation) to:

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