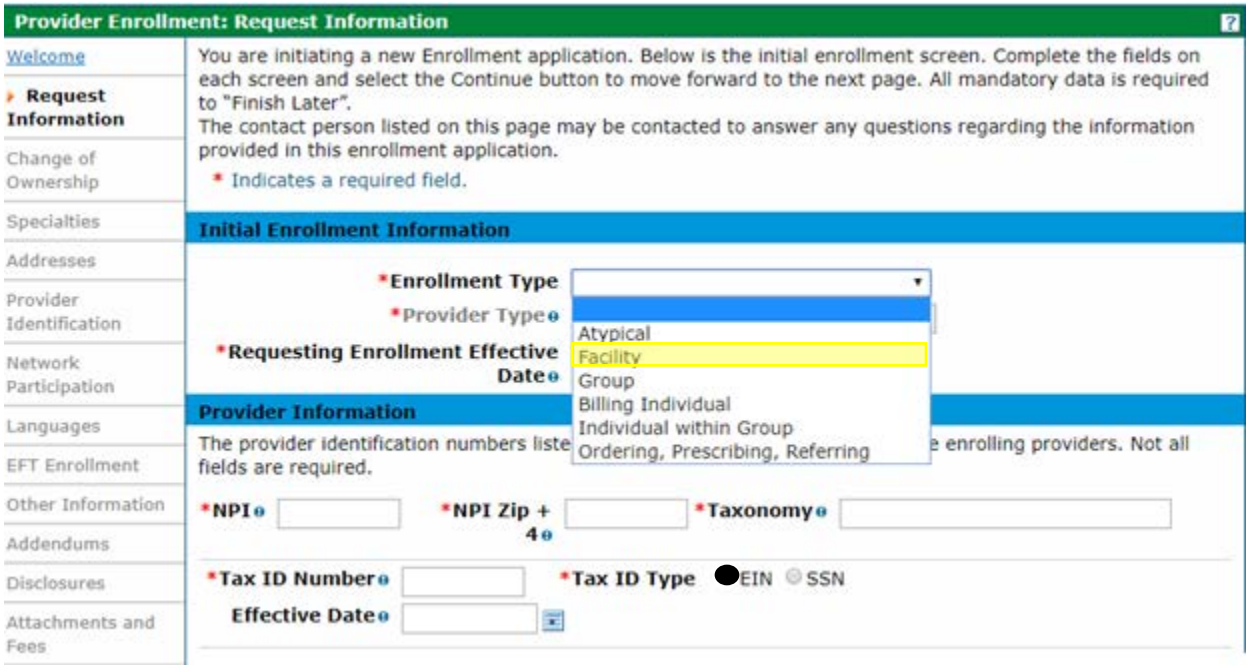

Figure 1 - Online Provider Enrollment Tool - Request Information page

Request Information Page

☐ **Enrollment Type**

- Select the Facility enrollment type from the dropdown.

☐ **Provider Type**

- See a complete list of provider types on the Information by Provider Type web page.

☐ **Requesting Enrollment Effective Date**

- A future enrollment effective date is not allowed. A backdate (up to 365 days in the past) can be requested; however, the request is not a guarantee of approval. See the Backdate Enrollment Quick Guide.

☐ **National Provider Identifier (NPI)**

- Know the organizational (Type-2) NPI & zip code +4.
- Don't have an organizational NPI? One can be obtained from the National Plan & Provider Enumeration System website.
- The application will be returned for correction if an individual (Type-1) NPI is used on the application.

☐ **Taxonomy Code**

- A complete Health Care Provider Taxonomy Code Set can be found on the Washington Publishing Company's website.

- At least one of the taxonomy codes included in the application must match at least one of the taxonomy codes associated to the NPI in the National Plan & Provider Enumeration System (NPPES).
- Health First Colorado does not offer advice about which taxonomy code(s) should be used, but the NPPES NPI Registry lookup can be used to see the taxonomy codes that are currently associated with the NPI.

☐ **Tax ID Number**

- Enter the Federal Employer Identification Number (EIN) of the business and check EIN in the Tax ID Type.
- Effective date for the EIN can be left blank or enter a date equal to or earlier than the requested enrollment effective date.

☐ **Contact Information**

- This Contact email address will receive notifications regarding the status of the application.

Change of Ownership

☐ **Indicate if this enrollment is due to a change of ownership or EIN.**

Specialties Page

☐ **Specialty**

- Select the appropriate specialty from the dropdown.
- There are many instances where the only specialty option is the provider type chosen. If this is the case, select the only option available and then use the "Taxonomy" dropdown to indicate the area of specialty.

☐ **Additional Taxonomy Codes (optional)**

Addresses Page

☐ **Service Location Address Information (including zip code + 4)**

- The Primary Address check box must be checked for the service location address only.
- A primary email address and office phone number are required.
- Each service location requires a separate application.
- Service location must be a physical address and cannot be a PO Box.
- Including the 9-digit (zip code + 4) service location zip code is crucial for claims payment. Don't know the 9-digit zip code? Look it up on the USPS website.

☐ **Billing Address Information (including zip code + 4)**

- Do not check the Primary Address check box for the billing address.
- A primary email address and office phone number are required.
- A "Pay to Name" is required; e.g. Office Manager, Billing Manager.
- One of the addresses (service location, billing or mailing) must match the address on the W-9.

☐ **Mailing Address Information**

- Do not check the Primary Address check box for the mailing address.
- A primary email address and office phone number are required.
- A "Mail to Name" is required (e.g. Attn: Front Desk)

Provider Identification Page

☐ **Provider Legal Name**

- The "Provider Legal Name" field currently only allows 50 characters, and "Doing Business As" allows 30 (including spaces). Please truncate Legal and DBA names, if necessary.
- The "Doing Business As" is optional. If a DBA is used, please enter it exactly as registered.

☐ **Organization Structure**

- This should match the federal tax classification indicated on the W-9.

☐ **Durable Medical Equipment Information (if applicable)**

- Bond #, effective date, end date, ACC effective date, and ACC end date.

☐ **License Information (if applicable)**

- License #, effective date, end date, and license state. Be sure to enter the entire license number including alpha and numerical characters as well as dots, dashes, etc.
- Don't forget to attach a copy of the license on the Attachment and Fees page of the application.

☐ **Medicare Number (if applicable)**

- The Effective Date for the Medicare number and the Medicare Type is needed.
- The information included in the application should match what was submitted to Medicare.

☐ **Clinical Laboratory Improvement Amendments (CLIA) information (if applicable)**

- CLIA #, effective date, and end date.

☐ **Drug Enforcement Administration (DEA) information (if applicable)**

- DEA # and effective date.

☐ **National Council for Prescription Drug Programs (NCPDP) information (if Pharmacy)**

- NCPDP ID # (if applicable)
- Pharmacy Classification (required)
- Do not forget to attach proof of NCPDP on the Attachments and Fees page of the application. Please follow the instructions to download proof of the NCPDP.

Network Participation Page

☐ **MCO/RAE Network**

- Participate in any of Colorado Medicaid's Managed Care Organizations (MCO) or Regional Accountable Entities (RAE)?
- For each MCO or RAE contracted with, attach a copy of one of the following on the Attachment and Fees page of the application:
    - A completed Network Participation Verification Form; **or**
    - The contract page(s) that identifies the contracting parties, the program name (e.g. Denver Health Medicaid Choice, Colorado Access, etc.) and the page(s) with signatures of both parties, including the date; **or**
    - The entire contract with the MCO or RAE.

Languages Page

☐ **All languages that are able to be translated (if applicable)**

EFT Enrollment Page

☐ **Federal Agency Information (if applicable)**

- Federal Program Agency name, identifier, and location code.

☐ **Retail Pharmacy Information (if applicable)**

- Pharmacy name, chain number, parent organization ID, payment center ID, NCPDP number, and Medicaid provider ID.

☐ **Financial Institution Information (this is required)**

- Financial Institution name, ABA routing number, type of account (checking/savings), account number, and the EIN or NPI.
- Have a copy of a W-9 and a bank letter or voided preprinted check, to attach later in the application. The W-9 and bank letter must be dated within the last 6 months.

Note: EFT is required for all applications except for Out-of-State providers, and Colorado State Government Entities. If qualified for an EFT exemption and not wanting to provide EFT information, please follow these EFT Exemption Instructions.

Other Information Page

☐ **Insurance Information**

- Carrier name, policy ID, effective date, and expiration date.
- Do not forget to attach a copy of the insurance face sheet on the Attachment and Fees page of the application.

☐ **Board Certification Information (if applicable)**

- Specialty, certification, effective date, end date, certification #.
- If the certification does not have an end date, use 12/31/2299. If there is no certification number, enter "N/A".

☐ **Supplemental Questions - Out-of-State Pharmacy Questionnaire (if Pharmacy)**

NOTE: The out of state Pharmacy Questionnaire is no longer required. The questionnaire will still appear in the application, however due to legislative changes it is no longer required to be completed.

☐ **Supplemental Questions – Medicaid Participation**

- Answer yes or no as applicable to each of the questions. Enter the applicable states for each yes answer.

☐ **Website address (optional)**

Addendums Page

☐ **Pharmacy Dispensing Fee Addendum (if Pharmacy)**

- Note: This list of questions provided for convenience only. Addendum MUST be completed from within the application.
- Please list the total number of prescriptions dispensed in the last 12 months. If the pharmacy has been open for less than 12 months, please list the total number of prescriptions dispensed for the months the pharmacy has been open. If the pharmacy is the only Medicaid-participating pharmacy within twenty miles (driving distance) of its physical location, then claim "Yes" on the rural line. NOTE: The prescription date range should not exceed one (1) year.
    - Total prescriptions, from date, to date, rural (y/n).
    - Please list the approximate percentage of prescriptions dispensed for each classification NOTE: The percentages should add up to 100%.
    - Medicaid %, Medicare %, other third-party %, cash %.

Disclosures Page

☐ **Disclosure Information**

- Health First Colorado cannot advise providers on how to determine owner data and controlling interest requirements, but can provide the following resources:
  - Disclosure Completion Instructions for Enrollment using a Federal Employer Identification Number (EIN).
  - The enrolling entity is the "disclosing entity" for the purpose of these questions.
- **School Health Services providers** - see the Information by Provider Type web page under "School Health Services", for disclosure instructions specific to the provider type.

Attachment and Fees Page

Scan and attach:

☐ **Insurance face sheet**

☐ **Certifications and licenses (if applicable)**

- Please see the Information by Provider Type web page for a list of requirements based on provider type.

☐ **W-9 (signed and dated within the past 6 months)**

- The address on the W9 must match one of the addresses entered in the application.

☐ **Voided check or bank letter (bank letter signed and dated within the past 6 months)**

- Voided checks must be preprinted; temporary checks are not accepted. The imprinted name on the check or bank letter needs to match the legal or DBA name.

☐ **For each MCO or RAE contracted with, a copy of one of the following is required:**

- A completed Network Participation Verification Form; **or**
- The contract page(s) that identifies the contracting parties, the program name (e.g. Denver Health Medicaid Choice, Colorado Access, etc.) and the page(s) with signatures of both parties, including the date; **or**
- The entire contract with the MCO or RAE.

☐ **Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable)**

☐ **Hardship waiver request letter and supporting documentation (if applicable)**

☐ **Proof of payment**

- If the application fee for Medicare or another state's Medicaid program, for this service location, has already been paid.

☐ **For application fee payment:**

- Please see the Information by Provider Type web page for a list of requirements based on provider type to determine if an application fee is required.
- Either a credit card number or EFT account information is needed.
- Application fee can only be paid online (via the Attachments and Fees page of the application).
- Credit card payment-processing fee is an additional 2.95%; EFT payment-processing fee is $2.50.

Agreement

☐ **The terms of enrollment are identified in the Provider Participation Agreement which must be read, agreed to and accepted for enrollment.**

Summary

☐ **Review all data entered in the enrollment application, make additional changes if needed and print a file copy of the application.**