COLORADO
Department of Health Care Policy & Financing

DXC Technology
P.O. Box 30
Denver, CO 80201

Fingerprint Criminal Background Check Other State/Medicare Information Form

Complete this form if fingerprints have been submitted and approved by Medicare or another State Medicaid Agency. Please type or print clearly.

Legal Name of Business(es) or Individual Provider: _____

Health First Colorado Program Provider ID: _____

List all Individual(s) with 5% or more ownership/control interest and last 4 digits of SSN for each (attach a separate page if more room is needed):

Name	Last Four of SSN	Fingerprints Submitted to Medicare	Other State Medicaid	States
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	

Contact Information:

Name: _____ Phone: _____

Email: _____

Please complete this form and mail it to:

DXC Technology
Attn: Provider Enrollment - Fingerprinting
P.O. Box 30
Denver, CO 80201