

THE COLORADO MEDICAL ASSISTANCE PROGRAM

Provider Services  
P.O. Box 1100  
Denver, CO 80201-1100

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**Provider Enrollment Application Check List and Instructions for a Hospice**

**(Standard Provider Application for Direct Pay Enrollment.)**

*Provides palliative/comfort care for patients with a terminal illness defined as a prognosis of life expectancy of 6 months or less. Services consist of nursing, certified nurse aide, physical therapy, counseling, or trained volunteers, and bereavement services.*

*The documents listed below are required and must be submitted with the application.*

<input type="checkbox"/>	<b>Completed Electronic Funds Transfer (EFT) Form</b> – The legal business name on this form must match exactly with the name on file with the IRS. The address on this form must match one of the addresses listed in the application. This form must be completed using the employer identification number assigned to the business.
<input type="checkbox"/>	<b>Completed W-9 Form</b> – The legal business name on this form must match exactly with the name on file with the IRS. The address on this form must match one of the addresses listed in the application. This form must be completed using the employer identification number assigned to the business.
<input type="checkbox"/>	<b>License-</b> Attach a copy of the license from the Department of Public Health and Environment.
<input type="checkbox"/>	<b>Medicare Certification</b> – Attach a copy of the Medicare Approval/Certification Letter.
<input type="checkbox"/>	<b>Completed Provider Disclosures Section</b> -- Check the appropriate entity type for the applicant (see definitions provided at the end of the section). Fields A through F must be completed with the requested information, check the box in the instruction area if the field is not applicable. If any area is not completed with either information or a check in the box, the application will be considered incomplete.