

THE COLORADO MEDICAL ASSISTANCE PROGRAM

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

1-800-237-0757
Fax: 303-534-0439

Provider Enrollment Application Check List and Instructions For Hospital Providers

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

<input type="checkbox"/>	Completed Electronic Funds Transfer (EFT) Form – 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.
<input type="checkbox"/>	Completed W-9 Form – 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.
<input type="checkbox"/>	License – Attach a copy of the license and the Department of Public Health and Environment certification. In-state hospitals require a contract with the Colorado Department of Health Care Policy and Financing.
<input type="checkbox"/>	Insurance – Attach proof of liability fidelity insurance.
<input type="checkbox"/>	Medicare Certification – Attach a copy of the Medicare Approval Certification Letter.
<input type="checkbox"/>	CLIA Certification – Attach copy of Clinical Laboratory Improvement Amendments Certificate of Accreditation.
<input type="checkbox"/>	Completed Provider Disclosures Section -- 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.