Load Letter Request Form

NOTE: The Department will accept requests on this form only. **Please write legibly**. Forms missing information will be sent back to the requestor which will cause a delay in the request. If you have any questions, please email: loadletterrequests@hcpf.state.co.us.

Please refer to the Billing Manuals section of the Department's Web site to review timely processing requirements.

Today's Date: ___________

Member Information:

State Medicaid ID: ________________ DOB: _____________ SSN: __________________

Last Name: ____________________________ First Name: _________________________

Dates of Service to be covered with the Request: __________________________________

Return Completed Request Form to:

Provider Name: _________________________Provider NPI: _______________

Name of Contact: _______________________ E-mail______________________________

Phone Number: _________________________Fax Number: ______________________

Please check the box if you **only want a fax response** to your request. ☐

Please indicate the **reason for requesting a Load Letter** below:

Send your request form by **ENCRYPTED** Email to: loadletterrequests@hcpf.state.co.us

If you are unable to send encrypted email, you may also fax your request to: **303-866-2082.** No cover sheet is needed.

DO NOT ALTER THIS FORM

*(*For Department Use Only: Please leave this section blank)*

** Eligibility Authorization Date: ___________ * Eligibility Transmit Date: ___________*

**County of Residence: _____________________*Case number______________*

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