Health First COLORADO
Colorado's Medicaid Program

DXC Technology
P.O. Box 30
Denver, CO 80201
Provider Call Center: 1-844-235-2387

Legal Name Change Form

Please complete this form to request a legal name change for an existing provider.

Provider Request

Tax ID Number: ______________________

Please note that the legal name will change for all providers with this Tax ID.

Current Provider Name (Business or Individual):

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New Legal Name:____

Location Address:____ Address Line 2:____________________________

City:____________________________________ State:____________________________ Zip Code:________________

For an Individual name change, please attach a SSN card, marriage license or legal name change document. The individual must sign this form.

For a group or facility name change, please attach a 147C from the IRS and a current W9. A representative may sign this form on behalf of the group.

Provider/Provider Representative Name (please print): ____

*Provider/Provider Representative Signature:*______________________________________*Date:*__________________

Contact Information: Phone:______________________Email: ____

Please complete this form and mail it to:
DXC, Attn: Provider Enrollment
P.O. Box 30

Denver, CO 80201

For questions regarding Health First Colorado enrollment, please call Provider Services at 1-844-235-2387.