

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
Psychiatric Residential Treatment Facility (PRTF)
(Standard Provider Application for Direct Pay Enrollment.)**

Provides outpatient mental health services.

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. This form must be completed using the employer identification number assigned to the business.
<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. This form must be completed using the employer identification number assigned to the business.
<input type="checkbox"/>	License - Attach a copy of the state license from the Department of Human Services.
<input type="checkbox"/>	Certification - Attach a copy of the certification from the Department of Public Health and Environment.
<input type="checkbox"/>	Completed Provider Disclosure 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 box, the application will be considered incomplete.
<input type="checkbox"/>	Special Instructions - Attach a copy of the signed Attestation Letter. (After enrollment is approved annual submission of this letter should be sent directly to the Colorado Department of Health Care Policy and Financing at 1570 Grant Street, Denver, Colorado 80203.)