

THE COLORADO MEDICAL ASSISTANCE PROGRAM

Medical Assistance Program Provider Services
 P.O. Box 1100
 Denver, CO 80201-1100
 1-800-237-0757



COLORADO
 Department of Health Care
 Policy & Financing

PROVIDER ENROLLMENT UPDATE FORM

Only one provider may be updated per form. Please complete all applicable information, sign and date this form (page 2), and send to the address indicated above. Please allow 10 calendar days from date of mailing to process your updates.

Date*: _____ / _____ / _____	Medical Assistance Program Provider Number*: _____
Provider Name*: _____	Tax ID (EIN or SSN)*: _____

DEMOGRAPHICS – Update your address(es) (May indicate "Same" if updating multiple addresses, at least one must be completed)		
<input type="checkbox"/> Billing – Used for payments	<input type="checkbox"/> Location – May require state approval	<input type="checkbox"/> Mail-To – Used for correspondence
Street	Street	Street
City	City	City
State Zip	State Zip	State Zip
Phone Number	Phone Number	Phone Number
Fax Number	Fax Number	Fax Number

BACKDATE ENROLLMENT – Request an effective date prior to the current enrollment effective date
<input type="checkbox"/> Please backdate my enrollment effective date _____ / _____ / _____ (Please use a 4-digit year) to: _____
Please attach rationale for being backdated to the requested date. Requests for over 120 days from the current effective date will require state approval.

NATIONAL PROVIDER IDENTIFIER (NPI) – Provide your NPI(s) (attach additional sheets if needed)
Number: _____ Taxonomy: _____ Effective Date: _____ / _____ / _____ Number: _____ Taxonomy: _____ Effective Date: _____ / _____ / _____

LICENSURE – Provide documentation for the license being updated
Number: _____ Effective Date: _____ / _____ / _____ Exp Date: _____ / _____ / _____ Documentation: <input type="checkbox"/> Copy of Updated License <input type="checkbox"/> DORA Licensure Verification Printout Only applicable to provider types licensed by DORA

DRUG ENFORCEMENT ADMINISTRATION (DEA) – Provide your DEA number
DEA Number: _____ Effective Date: _____ / _____ / _____

*Indicates required fields for all update requests

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ADD AFFILIATION(S) – <u>Add</u> affiliation(s) to your provider file (attach additional sheets if needed)		
Provider ID: _____	Name: _____	Eff. Date: ____ / ____ / ____
Provider ID: _____	Name: _____	Eff. Date: ____ / ____ / ____
Provider ID: _____	Name: _____	Eff. Date: ____ / ____ / ____

REMOVE AFFILIATION(S) – <u>Remove</u> affiliation(s) from your provider file (attach additional sheets if needed)		
Provider ID: _____	Name: _____	End Date: ____ / ____ / ____
Provider ID: _____	Name: _____	End Date: ____ / ____ / ____
Provider ID: _____	Name: _____	End Date: ____ / ____ / ____

PUBLICATION PREFERENCE – Change notification method and update your email address	
<input type="checkbox"/> Change my publication media to electronic (you will no longer receive paper bulletins)	
<input type="checkbox"/> Update my email address	Email: _____

TERMINATE ENROLLMENT – Please indicate the reason(s) for termination and effective date	
Dissatisfied with the: <input type="checkbox"/> Department of Health Care Policy & Financing <input type="checkbox"/> Fiscal Agent <input type="checkbox"/> Prior Authorization Process <input type="checkbox"/> Reimbursement Rates	Provider is Not Dissatisfied, I am/we are: <input type="checkbox"/> Changing Ownership and not Re-Enrolling <input type="checkbox"/> Leaving the Medical Field <input type="checkbox"/> Moving Out of State <input type="checkbox"/> Other Reason(s) (please indicate): _____
Effective Date: ____ / ____ / ____	Comments: _____ <small>Attach additional sheets if needed</small>
May we contact you for further follow-up regarding your termination? <input type="checkbox"/> Yes <input type="checkbox"/> No Contact Person: _____ Phone #: _____	

CERTIFICATION STATEMENT – Please read the following, sign, and date	
I certify by my signature below that I am fully authorized to sign and execute this Enrollment Update on behalf of the aforementioned provider. I understand that any information requested and provided on this form does not change or alter the terms of my executed Provider Participation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a Colorado Medical Assistance Program provider, and/or may be prosecuted under applicable federal and state laws.	
Name*: _____	Title*: _____
Signature*: _____	Date*: ____ / ____ / ____
An authorized agent must sign if you are a group provider or the actual provider must sign if you are an individual provider. <i>Unsigned forms will not be processed and will be returned.</i>	

*Indicates required fields for all update requests