



Publication Email Notification Preference

The Colorado Medical Assistance Program communicates important notices (including time-sensitive information), updates, billing instructions and bulletin links via email as soon as the information is available. *Providers are responsible for ensuring that the fiscal agent has their current email address on file. The Colorado Medical Assistance Program is not responsible for undeliverable notifications due to incorrect email addresses.*

All publications are available in the [Provider Services](http://colorado.gov/hcpf) section of the Department's website at colorado.gov/hcpf.

Please complete the following information:

Provider Name: _____ Colorado Medical Assistance Program Provider Number: _____

Contact Name: _____ Telephone Number: (_____) _____

Provider Email Address: _____

*Please note that only **one** email address per provider may be on file.*

Publication Email Notification Preference (Please check one):

- Please email notifications and bulletin links to me.
- Another provider will receive email notifications and bulletin links on my behalf. *(I understand that I am responsible for obtaining the information from this provider and that I will **not** receive any email notifications from the Colorado Medical Assistance Program.)*
- None. *(I understand that I am responsible for retrieving publications from the Website and that I will **not** receive any email notifications from the Colorado Medical Assistance Program.)*

Authorized Signature

Date

Please complete all of the above information and

Fax to:

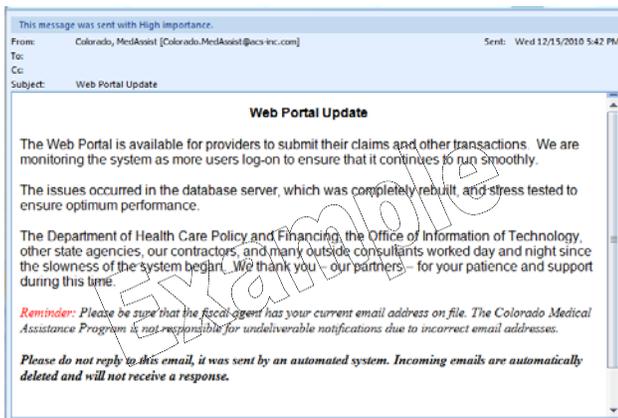
or

Mail to:

Colorado Medical Assistance Program Provider Enrollment
303-534-0439

Colorado Medical Assistance Program Provider Enrollment
PO Box 1100
Denver, CO 80201-1100

Important Notice Email Example



Monthly Bulletin Email Example

