COLORADO
Department of Health Care Policy & Financing

Revised: 121515

Provider Application Fee Refund Request Form

Please complete this form to submit a request for reimbursement of a provider application fee.

Section 1 – Contact Information

Full Legal Name:_____

DBA Name:_____

Email:_____ Phone:_____

Section 2 – Explanation of Request

Please provide a detailed explanation for your application fee refund request:

Please note: Convenience Pay processing fees are non-refundable.

Tracking Number (ATN):_____ NPI #:_____ Payment Confirmation #:_____

Please allow 30 days processing time to receive an approved refund. Refund will be credited back to the original credit/debit card or bank account used to make the payment.

Authorized Requestor Name:_____ Date:_____

Title:_____

By selecting the "I Accept" button, you are signing this Provider Application Fee Refund Request Form electronically. By submitting this form, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

☐ I Accept - I understand that my electronic signature is equivalent to written signature.

Attention: "Save As" completed form & email to Provider.Enrollment@state.co.us.
Paper copies of this form will not be accepted.

Reset Save As