COLORADO
Department of Health Care Policy & Financing

Third Party Reporting Form

For the purposes of coordinating third party liability, providers are asked to complete this form when a patient or his/her representative requests copies of bills for medical services paid by the Health First Colorado Program.

Please forward or fax one copy of the completed form to the following address:

Colorado Department of Health Care Policy and Financing

Benefits Coordination Section
1570 Grant Street
Denver, CO 80203

Fax: 303-866-3552

Date records requested: _____

Provider: _____ Health First Colorado provider #: _____

Member information:

Name: _____ Health First Colorado Program State ID #: _____

Home phone #: _____ Address: _____

Work phone #: _____ _____

_____

Dates of Service: _____

Reason for Request: _____

Party requesting information (if other than member):

Name: _____ Relationship to member: _____

Phone #: _____ Address: _____

_____

_____