# REQUEST FOR INSURER INFORMATION

## Colorado Division of Workers' Compensation Coverage Enforcement

**You must complete and return this form within 20 days of _____.**

Failure to complete this form in a timely manner will delay the claim process and may result in penalties. Please type or print the contact information and sign the form. See Page 3 for instructions.

A Block Number will be assigned to the insurer by the Division of Workers' Compensation once we have received the completed form. This number identifies the carrier in our system and must be used on required forms, including First Report transmittals and correspondence submitted to the Division.

If you already have a block number with the Division, please list it here: _____.

### 1. Insurer - Home Office

Name of Carrier

NCCI Provider Group ID#

Carrier FEIN #

NCCI Provider ID#

Street Address/P.O. Box

Phone #

City, State, Zip

Fax #

### 2. Office Servicing Colorado for Carrier (NOT Third Party Administrator - TPA)

Name of Carrier

Phone #

Street Address/P.O. Box

Fax #

City, State, Zip

### 3. Colorado Claims Contact (NOT Third-Party Administrator-TPA)

Name of Claims Contact

Email Address

Street Address/P.O. Box

Phone #

City, State, Zip

Fax #

### 4. Proof of Coverage Contact

Name of Proof of Coverage Contact

Email Address

Street Address/P.O. Box

Phone #

City, State, Zip

Fax #

### 5. Premium Surcharge Contact

Name of Premium Surcharge Contact

Email Address

Street Address/P.O. Box

Phone #

City, State, Zip

Fax #

## 6. EDI Business Contact

Name of EDI Business Contact

Email Address

Street Address/P.O. Box

Phone #

City, State, Zip

Fax #

## 7. EDI Technical Contact

Name of EDI Technical Contact

Email Address

Street Address/P.O. Box

Phone #

City, State, Zip

Fax #

## 8. Office Adjusting Colorado Workers' Compensation Claims (Third Party Administrator–TPA)

If there is more than one adjusting company, attach additional pages with full information for each.

Name of Adjusting Company

Email Address

Street Address/P.O. Box

Phone #

City, State, Zip

Fax #

## 9. Person Completing Form (Please Type or Print)

Name

Email Address

Title

Phone #

Signature (REQUIRED)

Date

**Return this form to:**

**Division of Workers' Compensation**
**Coverage Enforcement Unit**
**633 17th Street, Suite 400**
**Denver, CO 80202**

# INSTRUCTIONS

1. Complete the name, address, phone and fax numbers of the **Home Office** of the insurer. Enter the Federal Employer Identification Number (FEIN), NAIC code and NCCI Carrier Code numbers for the home office of the insurance carrier.
2. Complete the name, address, phone and fax numbers of the **office that services Colorado**. This is the address that the Division uses to send correspondence such as rules and administrative notices. If this section is blank, correspondence will be sent to the Home Office listed in section #1 above. If a Third-Party Administrator (TPA) services Colorado for the carrier, **do not list the TPA in this section**. List the TPA in Section #10.
3. Complete the name, address, phone and fax numbers, and email address for the person designated as the **Claims Contact for Colorado claims**. This person must be able to assist injured workers, deal with non-compliance issues, prepare for compliance reviews and have the authority to respond to audits by the Division of Workers' Compensation. This address will receive workers' claims for compensation, correspondence regarding admissions, notice of contest information, and similar correspondence. If a Third-Party Administrator (TPA) services Colorado for the carrier, **do not list the TPA in this section**. List the TPA in Section #10.
4. Complete the name, address, phone and fax numbers, and email address for the person designated as the **Proof of Coverage Contact for Colorado policies**. This person must be able to assist with policyholder FEIN questions and general policy inquiries from the Division. Reports, including Show Cause Orders, relating to the carrier's reporting of policy information are sent to this person.
5. Complete the name, address, phone and fax numbers, and email address for the person designated as the **Premium Surcharge Contact**. This person will receive premium surcharge notification letters and is responsible for completing the surcharge report and submitting payment to the Division.
6. Complete the name, address, phone and fax numbers, and email address for the person designated as the **Electronic Data Interchange (EDI) Business Contact**. This should be the person most familiar with the overall extract and transmission process within your business entity. This may be the project manager, business analyst, or claims manager. This person should be able to track down the answers to any business EDI issues that the EDI Technical Contact cannot address.
7. Complete the name, address, phone and fax numbers, and email address for the person designated as the **Electronic Data Interchange (EDI) Technical Contact**. This person will be contacted if issues regarding the actual transmission process arise. This person may be a telecommunications specialist, computer programmer or systems analyst.
8. If the insurer uses a **Third-Party Administrator (TPA)** to adjust Colorado claims, complete the name, address, phone and fax numbers of the TPA office. If there is more than one TPA office, or more than one location for the TPA, attach a separate page listing the required information for all additional TPA offices and/or locations.
9. Print the name, title, phone number, and email address of the person completing this form. This person must sign the form.

**Return the completed form to:**
**Division of Workers' Compensation**
**Coverage Enforcement Unit**
**633 17th Street, Suite 400**
**Denver, CO 80202**

**Any changes to this information must be reported to the Division of Workers' Compensation in writing.**
**If you have any questions, please contact the Division of Workers' Compensation at 303.318.8700.**