COLORADO
Department of Health Care Policy & Financing

gainwell

Fingerprint Criminal Background Check Other State and/or Medicare Information Form

Complete this form if fingerprints were submitted and approved by Medicare or another State Medicaid Agency. Type or print clearly.

Provider Request

Provider ID Number:_____

Provider Name (Business or Individual):_____

Location Address:_____ Address Line 2:_____

City:_____ State:_____Zip Code:_____

List all individual(s) with 5% or more ownership/control interest. Include the last four (4) digits of social security number (SSN). Attach a separate page if needed to list additional individuals.

Individual Name	Last Four Digits of SSN	Fingerprints Submitted to Medicare	Other State Medicaid	States
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	

Contact Name: (please print): _____

*Contact Name Signature:*_____ *Date:*_____

*Contact Information: Phone:*_____ *Email:*_____

Complete form and mail to:
Gainwell Technologies
Attention: Provider Enrollment - Fingerprints
P.O. Box 30
Denver, CO 80201