COLORADO
Department of Health Care Policy & Financing

Load Letter Request Form

Note: The Department will accept requests on this form only. Do not alter this form.

Claims must be submitted within 365 days, even if the result is a denial.

Providers are responsible for verifying member eligibility at time of service.
Refer to the Billing Manuals web page of the Department's website to review timely processing requirements.

Provider Request

Today's Date: _____

Member Information:

Health First Colorado ID:_____DOB:_____SSN:_____

Last Name:_____First Name: _____

Dates of Service to be covered with the request: _____

Internal Control Number (ICN) that was previously submitted within 365 days from the date of service:

_____

Return Response to:

Medical Provider Name:_____Provider Health First Colorado ID: _____

Name of Contact:_____E-mail:_____

Phone Number:_____Fax Number: _____

Check the box if **only a fax response** is wanted for this request. ☐

Indicate the **reason for requesting a Load Letter:** _____

_____

Send this request form by **encrypted** email to: hcpf_loadletterrequests@state.co.us.

Revised: April 2023