

# Provider Enrollment Manual

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# Before Starting an Application

To navigate through the Provider Enrollment Portal, please have the latest version of one of the following browsers installed on the personal computer (PC).

- Internet Explorer Version 9.0 and later
- Firefox
- Safari
- Google Chrome

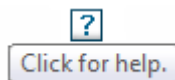
## More Information on a Field

Throughout the application a red asterisk (\*) next to a field indicates the field could either be required information or optional, if the user begins entering data.

In certain fields, additional information can be found by hovering the cursor over the symbol. Hovering over this symbol will open a gray box that will give more information about the field. The gray information box will disappear when the cursor is moved.

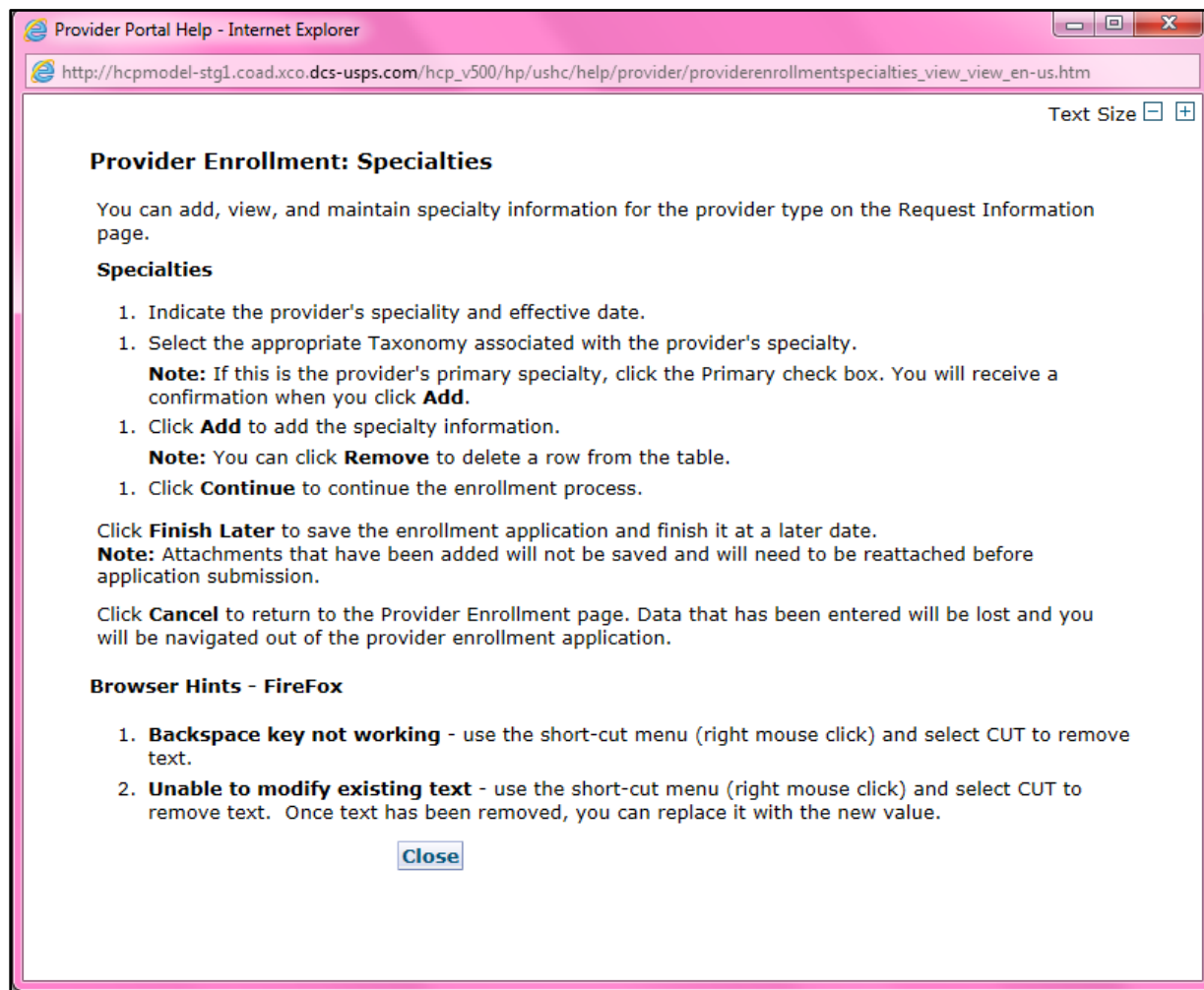


## Help Feature on Each Panel



Throughout the application there is a question mark symbol towards the top right corner of each panel. Clicking on it will open a dialog help window specific to the screen the user is currently in:

The example below displays the Specialties Help panel. The screen may look similar to the following:



# Provider Enrollment Manual Overview

## Provider Type, Enrollment Type and Enrollment Requirements

**Enrollment requirements will vary depending on the provider type & enrollment type.** Having the required enrollment information for the provider and enrollment type available prior to beginning the application will help expedite the enrollment process.

Visit the [Information by Provider Type web page](#) to view additional enrollment requirements for the provider type. Visit the [Provider Enrollment Types web page](#) to view the allowable provider types for each enrollment type. The following section list the enrollment requirements for each enrollment type.

### Enrollment Types:

#### Individual within a Group:

This enrollment type is for an individual that renders services but does not bill Colorado Medicaid directly. These providers must be associated with a Group that submits claims on their behalf.

- Must use SSN as the Tax ID Type
- Must associate to at least one “Group” provider enrollment type
- The group that the individual will affiliate to must have an approved enrollment before the individual can enroll.

#### Group

This enrollment type is a clinic or practice that will submit claims on behalf of one or more practitioners enrolled as an Individual within a Group. Income is reported to the (Internal Revenue Service (IRS) under the business EIN.

- Must use EIN as the Tax ID Type
- Billing/direct pay entity
- Must have at least one enrolled “Individual within a Group” practitioner associated. (This association is indicated on the “Individual within a Group” application). Associations may be added, removed, or changed after enrollment by logging in to the provider web portal.

#### Billing Individual

This enrollment type is for an individual who receives direct payment for services rendered and submits claims for his/her own services. Income is reported to the IRS under the individual’s SSN.

- Must use SSN as the Tax ID Type
- Billing/direct pay entity

#### What if I am an Individual, but I want to use my EIN for enrollment?

This is a common scenario for individuals, such as physicians, who own their own practice. **Even if the individual is the only practitioner**, if using an EIN for billing, this is a business. In order to enroll the business, a group enrollment type application must be completed. In this example, a ‘Group’ enrollment

type application would need to be completed as a provider type '16 – Clinic Practitioner Group. **Must use EIN as the Tax ID Type and enter the group EIN tax ID.**

After the physician in this example has submitted an application for his/her business and it has been approved for enrollment, he/she would **also need to submit a second application as an Individual Within a Group with a provider type of "Physician" for themselves as the rendering practitioner.** While completing the "individual Within a Group" application, the physician will indicate that they are affiliated to the group that was enrolled for the business. **Must use SSN as the Tax ID Type and enter the individual SSN tax ID.**

This will allow the individual physician to bill under their business EIN and render services to members via the SSN enrollment.

### Facility

This enrollment type is for an entity that will be submitting claims for services rendered. An associated Individual within a Group provider enrollment type is **not** required.

- EIN only
- Billing/direct pay entity

### Atypical

An Atypical provider renders non-medical services. These providers may include, but are not limited to, Home and Community-Based Waiver Services (HCBS) providers, Managed Care Organizations (MCOs) and Regional Accountable Entities (RAE).

- Enrollment requirements vary. Visit the [Information by Provider Type web page](#) to view enrollment requirements.
- SSN or EIN tax ID type may be used depending on provider type requirements.

### Ordering, Prescribing, Referring (OPR)

This enrollment type is for individuals who **only** order, prescribe or refer items or services covered by Health First Colorado (Colorado's Medicaid Program) for Health First Colorado members. These physicians and other professionals are not enrolled as an Individual within a Group or a Billing Individual and will not submit claims for payment of services rendered.

- SSN only

### Program of All-inclusive Care for the Elderly (PACE)-Only Subcontractor

This enrollment type is for an entity or individual that has a valid contract with a participating PACE Organization. Once the PACE-Only Subcontractor is enrolled, the associated PACE Organization may submit PACE encounter claims listing the sub-contractor's provider number and information.

- SSN or EIN tax ID type may be used depending on provider type requirements.
- The PACE Subcontractor Participation Attestation Form is required for this enrollment type.
- PACE-Only Subcontractors are exempt from the following enrollment requirements:
  - Electronic Funds Transfer (EFT) Enrollment
  - Addendums
  - Disclosures
  - Fingerprinting

- Submission of licensure, certification, or insurance
- Application fee
- Provider Participation Agreement
- Site Visits
- PACE-Only Subcontractors cannot register for the Provider Web Portal and must contact the [Provider Services Call Center](#) to update their provider information or disenroll.

## Additional Required Information

**National Provider Identifier (NPI)** – The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. The NPI is a 10-digit numeric identifier. Not all provider types require an NPI. To apply for an NPI, visit the [National Plan & Provider Enumeration System \(NPPES\) website](#).

- To determine if an NPI is required, visit the [Information by Provider Type web page](#).
- See list below to verify which type of NPI is required based on the enrollment type.

Enrollment Type	Requirement
Group	Organizational NPI & associated zip code +4
Facility	Organizational NPI & associated zip code +4
Individual within a group	Individual NPI & associated zip code +4
Billing individual	Individual NPI & associated zip code +4
Ordering-Prescribing-Referring	Individual NPI & associated zip code +4
Atypical provider	*NPI may or may not be required
PACE-Only Subcontractor	*NPI may or may not be required

\*Not all Atypical providers require an NPI. Visit the [Information by Provider Type web page](#) or [Information by HCBS Specialty web page](#) to determine whether an individual or organizational NPI is needed for the selected Atypical enrollment.

**Provider Taxonomy Codes** – The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions designed to categorize the type, classification, and/or specialization of health care providers.

**Use the [Search NPI Records tool](#) to see the taxonomy codes that were used when originally applying for the NPI.**

### Address Information

**Service Address** – This is the location where services are rendered. This address populates the [Find a Doctor](#) directory used by members. The email address associated with the service location is used to send provider communications such as newsletters and bulletins.

**(Each service address for an organization requires a separate application and unique NPI.)**

**Mailing Address** – This address is where paper Prior Authorization Request (PAR) letters are sent if the provider is not receiving PAR letters electronically.



**Billing Address** – This address is where paper checks and remittance advice statements are sent if the provider is not receiving them electronically.

**Federal Employer Identification Number (EIN) vs Social Security Number (SSN)** – A EIN is used to identify a business entity; an SSN is used for individuals.

**Provider License Number (if applicable)** – This is the identification number assigned by licensing agencies.

**Completed W-9 Form (must be signed & dated within the last 6 months)**

Enrollment Type	Requirement
Group	W-9 with EIN
Facility	W-9 with EIN
Atypical provider	W-9 with EIN or SSN (as applicable)
Billing individual	W-9 with SSN
Individual within a group	not required
Ordering-Prescribing-Referring	not required
PACE-Only Subcontractor	not required

**Malpractice & Liability Insurance Information** – Insurance information must be entered on the application by all provider types. A copy of the current insurance face sheet is required for Nursing Facilities. (All other provider types are not required to attach a copy.)

**Banking Information**

Electronic Fund Transfers (EFT) is required for payments. A copy of a voided check or a bank letter that is signed and dated within 6 months of application submission must be uploaded to the application on the Attachments & Fees panel.

- Voided checks must be pre-printed. Checks cannot be handwritten or temporary checks.
- The printed name on the voided check must match either the legal name or the doing business as (DBA) name entered in the application.
- The routing number on the voided check must match the routing number entered on the EFT panel.
- The bank account number listed on the voided check must match the bank account number entered on the EFT panel.
- Deposit slips are not acceptable.

**If a bank letter is attached in lieu of a voided check:**

- The bank letter must be printed on the bank's letter head. It cannot be handwritten.
- The bank letter must be signed by a bank representative and dated within 6 months of the application submission.
- The account holder name must match the legal or DBA name in the application.
- The routing number listed on the bank letter must match the routing number entered in the EFT panel.

- The bank account number listed on the bank letter must match the bank account number entered in the EFT panel.

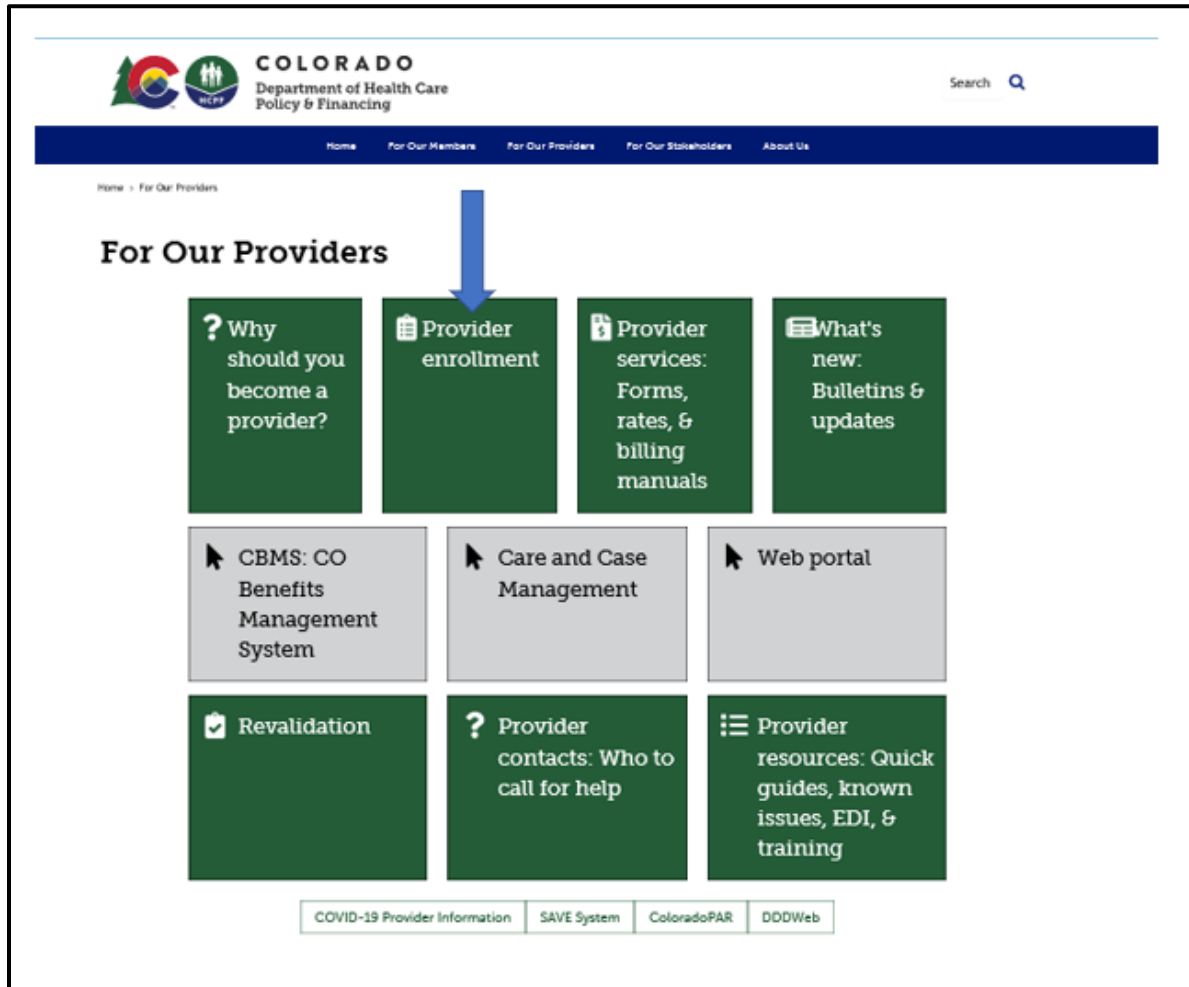
**Ownership/Controlling Interest & Conviction Disclosure Information**

For each person or entity with an ownership or control interest of 5% or more in the enrolling provider (including a Board of Directors with 0% ownership) the following information is needed:

- Name
- Address
- Federal employer ID number (EIN) or Social Security Number (SSN)
- Date of birth (DOB) if an individual

# Accessing the Provider Enrollment Portal

To access the Provider Enrollment Portal, open an internet browser, and visit the [For Our Providers web page](#). Click “Provider enrollment”.




Clicking on “**Provider enrollment**” brings up the [Provider Enrollment web page](#). Click on the Enrollment Instructions & Application button. [Read through the “Common Reason Enrollment Applications Are Returned to Providers” instructions and review each step to determine the Provider Type and Enrollment Type.](#)

**ATTENTION:** Some providers can now temporarily enroll in Health First Colorado (Colorado's Medicaid program) to provide services during the COVID-19 public health emergency. New applicants will be required to indicate whether they are enrolling temporarily due to the public health emergency or enrolling for the long-term. Refer to the drop-down section further down on this page, titled New Provider Specialties for COVID-19 Long-Term and Temporary Enrollment, for further details.

Revalidation Information

NPI Law Web Page

**Enrollment Instructions & Application**



## Enrollment Resources

- [Enrollment Best Practices](#)
- [Trading Partner Enrollment Information](#)
- [Enrollment and Web Portal Quick Guides](#)
- [Information for Ordering, Prescribing, Referring \(OPR\) Providers](#)

Need to speak to a live agent for help with your enrollment? Please call the Provider Services Call Center at 1-844-235-2387, then select option 2 and then option 5.

Completed your application? Click here for next steps

Provider Enrollment Forms can be found on the [Provider Forms web page](#) under the “Provider Enrollment & Update Forms” heading.

When ready to begin, click the “Go to Application” button at the bottom of the [Enrollment Type web page](#).

**IMPORTANT:** If choosing “Finish Later”, it is important to keep track of the tracking number, password, and the TAX ID used.

The Provider Portal Enrollment Application password cannot be reset. If the password has been forgotten, the application can still be resumed by choosing Forgot Password and then answering the security questions correctly. If both the password and the security answers are forgotten, a new application needs to be started.

It is acceptable to provide a PSV (Primary Source Verification) for the required documents. Copies of documents are accepted.

The application requires a mailing address, a service address, and a billing address. This does not mean that billing will occur.

All documents must be uploaded through the “attachments” section of the online application. **Note:** Upload all documents with the submission of the application. The system will not hold documents when “Finish Later” is selected.

Call the [Provider Services Call Center](#) if the tracking number is lost or for assistance.

Go to Application

After clicking “Go to Application”, the panel below will be displayed. Click the “Enrollment Application” link to begin the enrollment.

### *Provider Enrollment Home Panel*

**Home**

[Home](#) > Provider Enrollment

Wednesday 07/28/2021 05:04 PM MST

**Provider Enrollment**

[Enrollment Application](#)  
Initiate a new provider enrollment application.

[Resume Enrollment](#)  
Resume an existing enrollment application that has not been submitted.

[Enrollment Status](#)  
Check the current status of an enrollment application.

**Helpful Links**

[Provider Help](#)  
[Billing Manuals](#)  
[Provider Bulletins](#)

[Privacy Notice](#)

R05.00.298

The additional links on this panel are:

- **Resume Enrollment:** This allows the user to finish an enrollment application that was started earlier and saved or open an application that has been returned for correction. The user will

need the Application Tracking Number (ATN), the Tax ID enrolling on the application and the password that was set up when submitting or saving the application.

The screenshot shows a web form titled "Provider Enrollment: Resume Enrollment" with a green header bar. Below the header, there is a paragraph of instructions: "Enter your assigned Tracking Number, Tax ID and Password in order to resume an existing provider enrollment application. For any further queries, please refer to the [Provider Resources](#) web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment." Below this, a red asterisk indicates a required field. The form contains three input fields: "Tracking Number" (with a red error message "Tracking Number is a required field."), "Tax ID", and "Password". A "Forgot Password?" link is located to the right of the Password field. At the bottom right, there are "Submit" and "Cancel" buttons.

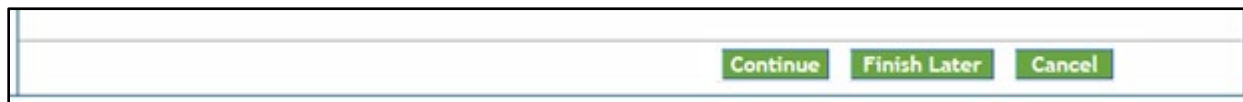
- **Enrollment Status:** This allows the user to check the status of a previously submitted application. The user may also view any comments left by reviewers here. The user will need the Application Tracking Number and the tax ID entered on the application.

The screenshot shows a web form titled "Provider Enrollment - Status" with a green header bar. Below the header, there is a paragraph of instructions: "Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment." Below this, a red asterisk indicates a required field. The form contains two input fields: "Tracking Number" and "Tax ID Number". At the bottom, there are "Search" and "Cancel" buttons. A "Back to Home" link is located in the top right corner of the header bar.

With a successful login, the user will see the status of the application and reviewer comments. This is also where the user will go if they disagree with a denied enrollment and need to submit a grievance. See the File a Grievance section for instructions on how to file a grievance.

## Completing the Application

The Provider Portal utilizes an autosave feature to automatically save entered data in the enrollment process. While completing the application, the user will see three buttons available at the bottom of each panel.

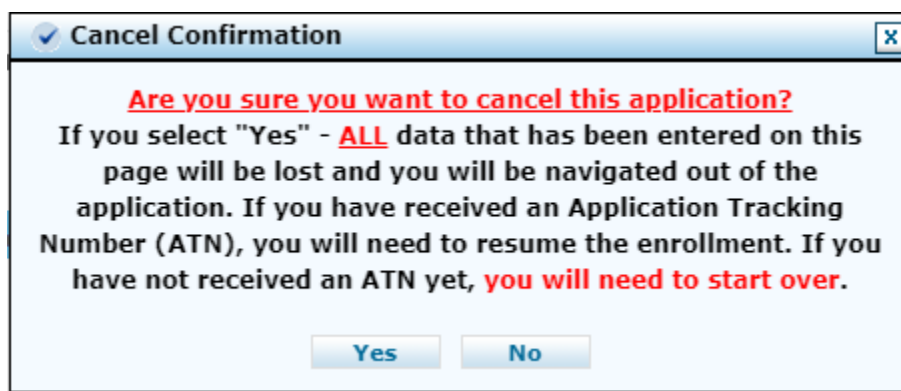


These buttons allow the user to:

**Continue** – Continue to the next panel of the enrollment application. The autosave process is initiated after entering data on the Request Information panel and clicking Continue. Each click of this button on subsequent panels will automatically save the data entered on the current panel.

**Cancel** – Stops the application process. If an Application Tracking Number (ATN) has been generated, this button will prompt the end of the application process without saving the data on the current panel (data entered on prior panels has already been saved). If an ATN has not been generated yet, this button will prompt the end of the application process **without saving the data**. Please note that a confirmation notification to cancel will appear before the user is allowed to proceed.

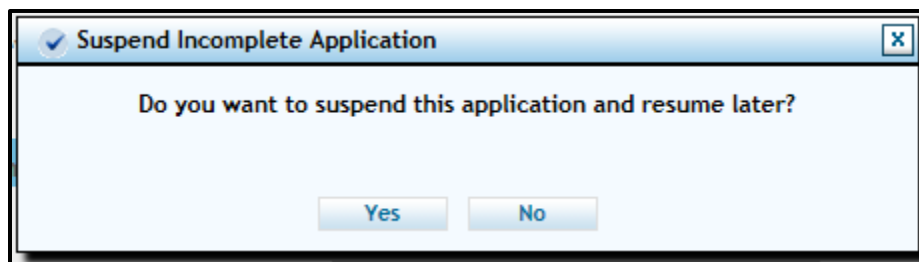
The Cancel Confirmation screen shown below will appear. If “Yes” is selected, all data entered on this and any previous panels will be lost if an ATN has not been generated.



**Finish Later** – Saves the information and allows the user to come back to the application later.

The following box will appear:

### *Suspend Incomplete Application Pop Up*



Select **“No”** and the user will return to the application process. Select **“Yes”** and the following Provider Enrollment Credentials panel will appear:

***Provider Enrollment: Credentials Panel***

**Provider Enrollment: Credentials** ?

Please provide your password and challenge question answers. Once your credential information is entered and the Submit button is selected, a tracking number will be provided and all subsequent panels will be automatically saved until the application is submitted. To save and access the enrollment application at a later date, click the Finish Later button. The tracking number along with your Tax ID and password will be used as your credentials to resume your incomplete application, or access your submitted application if it is returned to you for additional information.

You will have 60 days to complete your incomplete enrollment application and upon expiration, you will need to reinitiate a new enrollment application.

\* Indicates a required field.

Tax ID 650498709

\*Password

\*Confirm Password

\*What is your mother's maiden name?

\*What is your high school mascot?

\*What is your father's middle name?

**Submit** **Cancel**

**Password** – Select a password to use for the enrollment process. This field is required for all providers saving their application. This user-defined password must be between 8-20 alphanumeric characters.

**Confirm Password** – Confirm the password to use for the enrollment process. This field is required for all providers saving their application.

**What is your mother's maiden name?** – Enter mother's maiden name. This field is required for all providers saving their application. This user-defined response can have a maximum of 50 alphanumeric characters.

**What is your high school mascot?** – Enter a high school mascot. This field is required for all providers saving their application. This user-defined response can have a maximum of 50 alphanumeric characters.

**What is your father's middle name?** - Enter father's middle name. This field is required for all providers saving their application. This user-defined response can have a maximum of 50 alphanumeric characters.

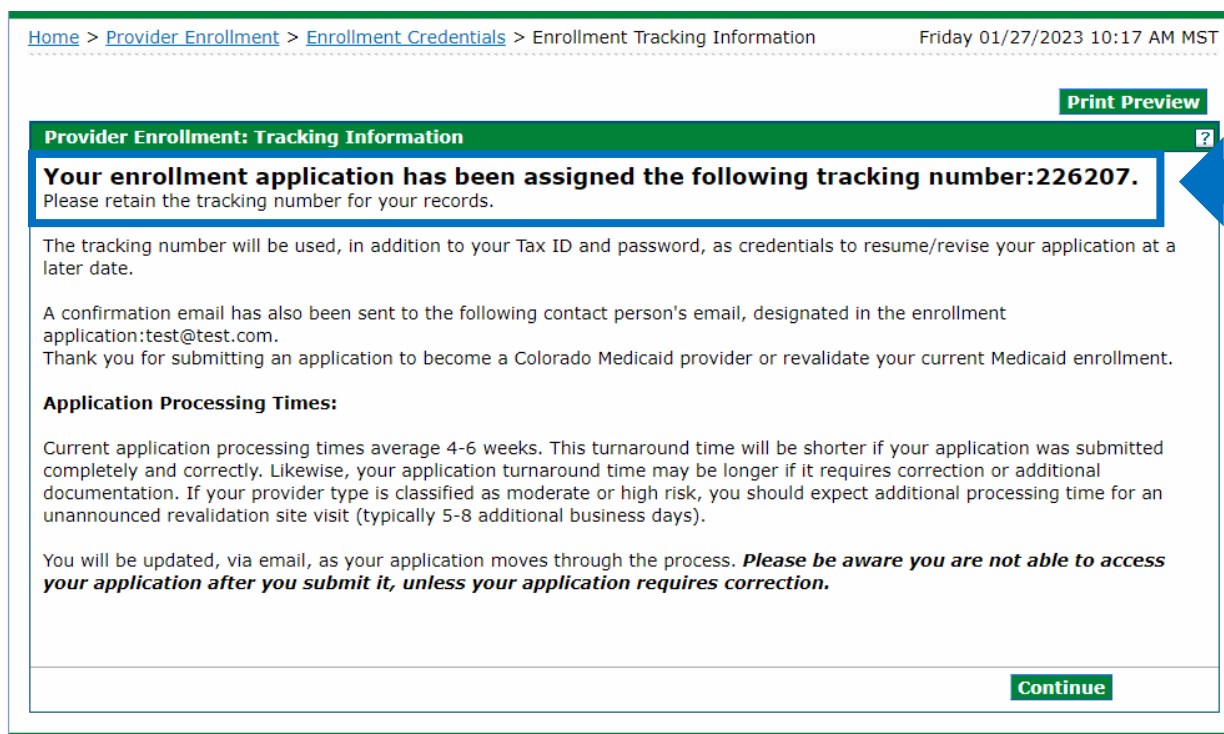
**Tip:** It is very important that the user store the password somewhere that they will not forget. The password cannot be reset for enrollment applications. If the password and security question answers are lost, the user will be unable to access the application and will need to begin a new enrollment application.

Select **“Submit”** to save this information and proceed to the next panel. Select **“Cancel”** to stop this process and return to the Enrollment process.

Once the user selects the **“Submit”** button, the user will be directed to the next panel that will assign the application tracking number. This panel will give the Application Tracking Number (ATN) that will be required to resume the application. In the upper right corner of this panel is a **“Print Preview”** button. Use this button to send a copy of this panel to a local or network printer connected to the computer.



### Provider Enrollment: Tracking Information Panel



Home > Provider Enrollment > Enrollment Credentials > Enrollment Tracking Information Friday 01/27/2023 10:17 AM MST

[Print Preview](#)

**Provider Enrollment: Tracking Information** ?

**Your enrollment application has been assigned the following tracking number: 226207.**  
Please retain the tracking number for your records.

The tracking number will be used, in addition to your Tax ID and password, as credentials to resume/revise your application at a later date.

A confirmation email has also been sent to the following contact person's email, designated in the enrollment application: test@test.com.  
Thank you for submitting an application to become a Colorado Medicaid provider or revalidate your current Medicaid enrollment.

**Application Processing Times:**

Current application processing times average 4-6 weeks. This turnaround time will be shorter if your application was submitted completely and correctly. Likewise, your application turnaround time may be longer if it requires correction or additional documentation. If your provider type is classified as moderate or high risk, you should expect additional processing time for an unannounced revalidation site visit (typically 5-8 additional business days).

You will be updated, via email, as your application moves through the process. ***Please be aware you are not able to access your application after you submit it, unless your application requires correction.***

[Continue](#)

Select **“Continue”** to resume the enrollment process.

Please note that on the upper left side of the panel, the bolded title indicates the panel that is currently open. Each panel becomes a clickable link as the panels are completed through the enrollment process, allowing a previous panel to be accessed if a change is needed.

Going back to a previous panel does not save the data entered. In order to save the data entered in an application click either the **“Continue”** or **“Finish Later”** buttons.

## Welcome Panel

Once the user is ready to begin the enrollment process and has selected the “**Enrollment Application**” link, the first panel is the Welcome panel.

**Colorado**  
Department of Health Care  
Policy & Financing

**Health First**  
**COLORADO**  
Colorado's Medicaid Program  
[Contact Us](#) | [Login](#)

[Home](#)

[Home](#) > [Provider Enrollment](#) > Enrollment Application

Thursday 08/05/2021 11:33 AM MST

**Provider Enrollment: Welcome**

<b>Welcome</b>	<p><b>Welcome to the Online Provider Enrollment Process</b></p> <p>The Provider enrollment application is not used to revalidate. Enrolled providers are instructed to visit the Revalidation FAQ page on the public website if they need to revalidate.</p>
Request Information	
Change of Ownership	Please complete each step in the enrollment process. Required fields are noted. You will be able to save the information and return using the tracking number assigned by the system. When you have completed all steps of the application, print a copy of the information for your records, "submit" and "confirm" the application for processing.
Specialties	
Addresses	Please click the “ <b>Continue</b> ” button to start the enrollment process.
Provider Identification	<p><b>Want to make sure your application is processed as quickly as possible?</b></p> <p>Please do NOT begin your application before reviewing all of the training resources available. Starting an application prior to reviewing the training materials will likely result in an incomplete or incorrect application. An incorrect or incomplete application requires additional review, which may add weeks of additional processing time. Please visit the <a href="#">Provider Enrollment web page</a>. Be sure to review the <a href="#">Find Your Provider Type web page</a> before you begin the online trainings – it will help you select the correct training, right from the start.</p>
Network Participation	
Languages	
EFT Enrollment	
Other Information	
Addendums	
Disclosures	
Attachments and Fees	
Agreement	
Summary	

[Continue](#) [Cancel](#)

The Welcome Panel gives some brief instructions. Select the “**Continue**” button to go to the next panel of the application.

## Request Information Panel

After clicking “Continue” from the Welcome Panel, the Request Information panel will be displayed.

Provider Enrollment: Request Information	
<a href="#">Welcome</a>	You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to the next page. All mandatory data is required to “Finish Later”. The contact person listed on this page may be contacted to answer any questions regarding the information provided in this enrollment application. * Indicates a required field.
<b>Request Information</b>	
Specialties	
Addresses	
Provider Identification	<b>Initial Enrollment Information</b>
Network Participation	The Requesting Enrollment Effective Date can be equal to today's date or up to 365 days prior to today's date if services were previously rendered.
Languages	*Enrollment Type <input type="text"/>
EFT Enrollment	*Provider Type <input type="text"/>
Other Information	*Requesting Enrollment Effective Date <input type="text" value="04/24/2023"/>
Addendums	<b>Provider Information</b>
Disclosures	The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.
Attachments and Fees	Enrolling providers must validate the entered taxonomy matches at least one taxonomy currently listed on NPPES for the NPI. Perform an NPPES search <a href="#">here</a> to verify the taxonomy.
Agreement	*NPI <input type="text"/>
Summary	*NPI Zip + <input type="text"/> *Taxonomy <input type="text"/>
	*Tax ID Number <input type="text"/> *Tax ID Type <input type="radio"/> EIN <input type="radio"/> SSN
	Effective Date <input type="text"/>
	<b>Contact Information</b>
	*Last Name <input type="text"/>
	*First Name <input type="text"/>
	Suffix <input type="text"/>
	*Phone <input type="text"/> Ext <input type="text"/>
	Fax Number <input type="text"/>
	*Contact Email <input type="text"/>
	*Confirm Email <input type="text"/>
	*Email For Provider Publications <input type="text"/>
	*Confirm Email <input type="text"/>
	Preferred Method of Communication <input type="text" value="Email"/>
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>

\*The example below is for an Individual Within a Group enrollment type. The panel screen may appear similar to the following.

Provider Enrollment: Request Information ?																										
<a href="#">Welcome</a>	<p>You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to the next page. All mandatory data is required to "Finish Later".</p> <p>The contact person listed on this page may be contacted to answer any questions regarding the information provided in this enrollment application.</p> <p>* Indicates a required field.</p>																									
▶ <b>Request Information</b>																										
Change of Ownership																										
Specialties																										
Addresses	<b>Initial Enrollment Information</b> <p>This enrollment type is for an individual that renders service but does not bill Colorado Medicaid directly. The provider must be associated with a Group that submits claims on their behalf.</p> <ul style="list-style-type: none"> <li>SSN only</li> <li>Must associate to a Group provider enrollment type</li> </ul> <p>*Enrollment Type <input type="text" value="Individual within Group"/></p> <p>*Provider Type <input type="text"/></p> <p>*Requesting Enrollment Effective Date <input type="text" value="09/09/2019"/></p>																									
Provider Identification																										
Network Participation																										
Languages																										
EFT Enrollment																										
Other Information																										
Addendums	<b>Group Association</b> <p>Enter your group affiliation information here.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.</p> <table border="1"> <thead> <tr> <th></th> <th>Group NPI</th> <th>Group Name</th> <th>Address</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td colspan="4">Click to collapse.</td> </tr> <tr> <td></td> <td>*Group NPI <input type="text"/></td> <td>Group Name <input type="text"/></td> <td>Service Location <input type="text"/></td> <td>City <input type="text"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>State <input type="text"/></td> <td></td> </tr> <tr> <td></td> <td colspan="4"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </td> </tr> </tbody> </table>		Group NPI	Group Name	Address	Action	<input type="checkbox"/>	Click to collapse.					*Group NPI <input type="text"/>	Group Name <input type="text"/>	Service Location <input type="text"/>	City <input type="text"/>				State <input type="text"/>			<input type="button" value="Add"/> <input type="button" value="Reset"/>			
	Group NPI	Group Name	Address	Action																						
<input type="checkbox"/>	Click to collapse.																									
	*Group NPI <input type="text"/>	Group Name <input type="text"/>	Service Location <input type="text"/>	City <input type="text"/>																						
			State <input type="text"/>																							
	<input type="button" value="Add"/> <input type="button" value="Reset"/>																									
Disclosures																										
Attachments and Fees																										
Agreement																										
Summary																										

Provider Information	
The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.	
Enrolling providers must validate the entered taxonomy matches at least one taxonomy currently listed on NPPES for the NPI. Perform an NPPES search <a href="#">here</a> to verify the taxonomy.	
*NPI	<input type="text"/>
*NPI Zip + 4	<input type="text"/>
*Taxonomy	<input type="text"/>
*Tax ID Number	<input type="text"/>
*Tax ID Type	<input type="radio"/> EIN <input type="radio"/> SSN
Effective Date	<input type="text"/>
Contact Information	
*Last Name	<input type="text"/>
*First Name	<input type="text"/>
Suffix	<input type="text"/>
*Phone	<input type="text"/>
Ext	<input type="text"/>
Fax Number	<input type="text"/>
*Contact Email	<input type="text"/>
*Confirm Email	<input type="text"/>
*Email For Provider Publications	<input type="text"/>
*Confirm Email	<input type="text"/>
Preferred Method of Communication	<input type="text" value="Email"/>
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>	

### Initial Enrollment Information Section

Initial Enrollment Information	
*Enrollment Type	<input type="text"/>
*Provider Type	<input type="text"/>
*Requesting Enrollment Effective Date	<input type="text" value="08/05/2021"/>

#### Enrollment Type

On this panel the user will select the Enrollment Type by clicking the drop-down next to Enrollment Type. Please see the 'Provider Enrollment Manual Overview' section above for explanation of enrollment types.

#### Provider Type

In the Provider Type field, enter two asterisks (\*\*) to see all valid provider type choices, specific to the Enrollment Type that was selected in the prior field. If \*\* does not return the correct value that the user

is trying to enter, type the first few characters of the word. For example, type “Phys” and the panel will return items with “Phys” in the value, e.g. Physician and Physician Assistant.

[The Information by Provider Type web page](#) is a link to the list of all the available provider types supported in the Colorado interchange. These are the **ONLY** provider types the system will accept.

For the purposes of this example, we will choose Physician.

### ***Requesting Enrollment Effective Date***

The "Requesting Enrollment Effective Date" field is defaulted to the current date for new enrollment applications. Users may enter a backdate up to 365 days prior to the current date in the "Requesting Enrollment Effective Date" field.

For providers resuming an enrollment application that is still in process, the "Requesting Enrollment Effective Date" field will be populated with the date entered when the application was last saved. That date must be within 365 days prior to the current date.

A backdate (up to 365 days in the past) can be requested; however, the request is not a guarantee of approval. Additionally, any required licenses, certifications, insurance, or specialties must be effective on the requested enrollment effective date.

Complete the remainder of the enrollment application. If the enrollment and backdate request are approved, the provider will receive a Welcome Letter which will contain the provider’s backdated contract effective date.

### **Group Association Section (Only for Individual Within a Group enrollment type)**

**Group Association**

Enter your group affiliation information here.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

Group NPI	Group Name	Address	Action
<input type="checkbox"/> Click to collapse.			
<b>*Group NPI</b> <input style="width: 100px;" type="text"/>	<b>Group Name</b> <input style="width: 100px;" type="text"/>	<b>Service Location</b> <input style="width: 100px;" type="text"/> <input style="width: 100px;" type="text"/> <b>City</b> <input style="width: 100px;" type="text"/> <input style="width: 100px;" type="text"/> <b>State</b> <input style="width: 100px;" type="text"/> <input style="width: 100px;" type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>			

This section of the Request Information Panel is the Group Association panel. This panel is required and will only display for providers that previously selected “Individual within a Group” as the Enrollment Type. All groups that the individual provider will affiliate to should be entered in this section.

Prior to completing this portion of the Enrollment process, please check with the Group representative(s) to make sure the groups are enrolled. If a Group is not enrolled, the affiliation cannot be completed.

### **Group NPI**

Enter the Group's NPI. If the NPI entered returns a single group location, the enrolled group's name, service location address, city & state will populate. Click the **"Add"** button to add this group affiliation.

If the group NPI entered is associated with multiple locations, an error message will display at the top of the panel indicating "Provider ID does not return a single Provider. Click the magnifying glass to search for a provider." Click the magnifying glass icon located next to the NPI field to display a list of address locations for the group NPI entered. Choose the appropriate address location from the list, then click the **"Add"** button to add the affiliation.

If the information is not correct and the user would like to start over, click the **"Reset"** button and re-enter the information.

After the user clicks the **"Add"** button, the panel will update and will look similar to the following:

### **Group Association Section - Add**

**Group Association**

Enter your group affiliation information here.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

	Group NPI	Group Name	Address	Action
+				<a href="#" style="color: #0070C0;">Remove</a>
+	Click to add Group Affiliation			

If an individual is part of more than one group, indicate all groups by adding each affiliation here. If an individual is affiliated to more than 16 groups, the 17<sup>th</sup> through last group will need to be a separate attachment uploaded in the "Attachment and Fees" panel.

### **Provider Information Section**

**Provider Information**

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

Enrolling providers must validate the entered taxonomy matches at least one taxonomy currently listed on NPPES for the NPI. Perform an NPPES search [here](#) to verify the taxonomy.

**\*NPI**

**\*NPI Zip + 4**

**\*Taxonomy**

---

**\*Tax ID Number**

**Effective Date**

**\*Tax ID Type** ☐ EIN ☐ SSN

Enter the requested information within this section for the provider who is enrolling on the application including NPI Number, Provider Taxonomy, and Tax ID.

**Note:** Not all provider types will have an NPI number. For the purposes of this example, the red asterisk indicating a required field is driven by the previous selection of “Physician”.

**NPI** – Enter the applicant’s 10-digit National Provider Identifier. This information is required for most provider types. Some Atypical providers may not need an NPI.

**NPI Zip + 4** – Enter the zip code associated with the service address, as listed in the [NPPES NPI Registry](#). Enter a 9-digit zip code. If an NPI is not required for the selected provider type, no entry is required in this field.

**Taxonomy Codes** – Enter the 10-digit alphanumeric Taxonomy code that classifies the enrolling provider as a healthcare provider according to the services provided. Entering two or more characters to begin a search populates a drop-down of applicable taxonomies where the user can then select an entry from the list that is shown. The entered taxonomy must match at least one taxonomy currently listed on NPPES for the NPI. After selecting a taxonomy, a popup must be acknowledged that the application will be returned or possibly denied if the taxonomy does not match before continuing the application.

If the selected provider type does not require an NPI, no entry is required in this field.

**Tip:** Refer to the ‘Provider Taxonomy Codes’ under the ‘Additional Required Information’ section of this manual for additional taxonomy code information.

**Tax ID Number** – Enter the 9-digit EIN or SSN associated with the enrolling provider. This field is required for all providers.

**Tax ID Type** – Select whether an EIN or SSN was entered in the Tax ID Number field. This field is required for all providers. Group, Facility, and some Atypical providers will require an EIN. Individual providers will require an SSN.

#### **Effective Date**

- If an EIN was entered - The effective date for this field should be the date the corporation (entity) began doing business.
- If an SSN was entered - The effective date for this field should be the practitioner’s date of birth.

#### **Contact Information Section**



Contact Information	
*Last Name	<input type="text"/>
*First Name	<input type="text"/>
Suffix	<input type="text"/>
*Phone	<input type="text"/> Ext <input type="text"/>
Fax Number	<input type="text"/>
*Contact Email	<input type="text"/>
*Confirm Email	<input type="text"/>
*Email For Provider Publications	<input type="text"/>
*Confirm Email	<input type="text"/>
Preferred Method of Communication	<input type="text" value="Email"/>

Indicate required contact information for the practice or organization on this panel.

**Last Name** – Enter the last name of the individual who will receive correspondence regarding this enrollment. This field allows up to 50 alphanumeric characters. This field is required for all providers.

**First Name** – Enter the first name of the individual who will receive correspondence regarding this enrollment. This field allows up to 25 alphanumeric characters. This field is required for all providers.

**Suffix** – If appropriate, enter the suffix for the name of the individual who will receive correspondence regarding this enrollment. This field allows up to ten alphanumeric characters. This field is not required.

**Phone** – Enter the office phone number of the individual who will receive correspondence regarding this enrollment. This field allows a 10-digit phone number, including area code using 999-999-9999 format. This field is required for all providers.

**Ext** – If appropriate, enter the phone extension of the individual who will receive correspondence regarding this enrollment. This field is not required.

**Fax Number** – Enter the fax of the individual who will receive correspondence regarding this enrollment. This field allows a 10-digit phone number, including area code using 999-999-9999 format. This field is not required.

**Contact Email** – Enter the valid Email address of the individual who will receive correspondence regarding this enrollment. Enter email with 'name@domain' format. This field is required for all providers.

**Confirm Email** – Confirm the valid Email address of the individual who will receive correspondence regarding this enrollment. Enter email with 'name@domain' format. This field is required for all providers.

**Email for Provider Publications** – Enter the valid Email address of the contact individual at the practice or organization to which Provider Publications should be sent. Enter email with 'name@domain' format. This field is required for all providers.

**Confirm Email** – Confirm the valid Email address of the contact individual at the practice or organization to which Provider Publications should be sent. Enter email with 'name@domain' format. This field is required for all providers.

**Preferred Method of Communication** – Selecting “Email” will ensure more timely receipt of correspondence.

## Change of Ownership Panel

After clicking “**Continue**” from the Request Information panel, entering Credential information, and generating an ATN, the Change of Ownership panel displays for Facility, Group or Atypical enrollment types.

**NOTE:** The Change of Ownership panel will not display for Individual within Group, Billing Individual, Ordering, Prescribing, Referring (OPR) or PACE-Only Subcontractor provider enrollment types.

The panel initially displays with the field "Is the application due to a change of ownership where the EIN is changing?" set to “**No**”.

### Change of Ownership and EIN Section

Indicate if this enrollment is due to a change of ownership or Federal Employer Identification Number (EIN).

For a “**No**” answer, click “**Continue**” to proceed to the next panel of the application.


A “**Yes**” answer displays the Previous Ownership section.

Provider Enrollment: Change of Ownership and Change of Federal Employer Identification Number (EIN) ?	
<a href="#">Welcome</a>	* Indicates a required field.
<a href="#">Request Information</a>	
<b>Change of Ownership</b>	<b>Change of Ownership and EIN</b> A change of ownership resulting in a change of EIN terminates the Provider Participation Agreement. New owners and providers with a new EIN must re-apply and complete a new Provider Participation Agreement to participate in Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+).  Claims cannot be submitted before the application is activated for the new enrollment. Additionally, claims may not be submitted by the new owner using the old EIN or the selling provider's NPI/Health First Colorado Provider ID.
Specialties	
Addresses	
Provider Identification	
Network Participation	<b>Change of Ownership and EIN</b> *Is this application due to a change of ownership where the EIN is changing? <input type="radio"/> Yes <input checked="" type="radio"/> No
Languages	
EFT Enrollment	<div>Continue Finish Later Cancel</div>
Other Information	
Addendums	
Disclosures	
Attachments and Fees	
Agreement	
Summary	

**Note:** Providers are reminded that new owners and providers with a new EIN must re-apply submitting a new enrollment application that includes the Selling Provider's information and a new Provider Participation Agreement. Changes in ownership that do not result in an EIN change may continue to be submitted through the Disclosures panel of the Provider Maintenance or Revalidation applications. A change of ownership or change in EIN is not applicable to an individual (SSN) enrollment. For additional information on Change of Ownership (CHOW), visit the [Provider FAQ Central](#) and select the Change of Ownership (CHOW) FAQs heading.

### Previous Ownership Section

Complete all the required fields under the Previous Ownership section with the selling provider's information.

Provider Enrollment: Change of Ownership and Change of Federal Employer Identification Number (EIN)	
<a href="#">Welcome</a>	* Indicates a required field.
<a href="#">Request Information</a>	
<b>Change of Ownership</b>	<b>Change of Ownership and EIN</b>
Specialties	A change of ownership resulting in a change of EIN terminates the Provider Participation Agreement. New owners and providers with a new EIN must re-apply and complete a new Provider Participation Agreement to participate in Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+).
Addresses	Claims cannot be submitted before the application is activated for the new enrollment. Additionally, claims may not be submitted by the new owner using the old EIN or the selling provider's NPI/Health First Colorado Provider ID.
Provider Identification	<b>Change of Ownership and EIN</b>
Network Participation	*Is this application due to a change of ownership where the EIN is changing? <input checked="" type="radio"/> Yes <input type="radio"/> No
Languages	<b>Previous Ownership</b>
EFT Enrollment	Enter previous ownership information. All fields are required. Click the magnifying glass to search for and select the appropriate Selling NPI/Health First CO Provider ID. The Change of Ownership Effective Date can be a retroactive date to the first of the current calendar year, the current date, or date in the future up to 90 days.
Other Information	
Addendums	
Disclosures	
Attachments and Fees	*Selling NPI/Health First CO Provider ID <input type="text"/>  *ID Type <input type="text"/>
Agreement	Name <input type="text"/>
Summary	*Selling Provider Contact Name <input type="text"/>
	*Selling Provider Contact Phone Number <input type="text"/>
	*Change of Ownership Effective Date <input type="text"/>
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>

**Selling NPI/Health First CO Provider ID** – Enter the Medicaid number or NPI number of the selling provider or previous provider. Click the magnifying glass to search for a provider.

**ID Type** – Use the drop-down to select the ID Type.

**Name** – This field will populate with the NPI/Provider ID being entered.

**Selling Provider Contact Name** – Enter the contact for the selling provider's first and last name.

**Selling Provider Contact Phone Number** – Enter the selling provider's phone number. This field allows a 10-digit phone number, including area code using 999-999-9999 format. This field is required.

**Change of Ownership Effective Date** – Enter the effective date of the change of ownership.

When all fields are entered, select **“Continue”**, **“Finish Later”** or **“Cancel”**.

**Note:** Upon receipt of a completed Change of Ownership enrollment application, the selling provider will receive a notification from Health First Colorado with instruction on submitting a voluntary disenrollment application. The change of ownership enrollment application cannot be processed for approval until the selling provider completes and submits a voluntary disenrollment application through the Provider Web Portal.

## Specialties Panel

[Welcome](#)  
[Request Information](#)  
**Specialties**  
[Addresses](#)  
[Provider Identification](#)  
[Network Participation](#)  
[Languages](#)  
[Other Information](#)  
[Addendums](#)  
[Disclosures](#)  
[Attachments and Fees](#)  
[Agreement](#)  
[Summary](#)

### Provider Enrollment: Specialties

The provider type is established on the Request Information screen. All specialties available for the selected provider type can be added on this screen.

\* Indicates a required field.  
☒ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

Specialty	Taxonomy	Effective Date	End Date	Action
<input type="checkbox"/> Click to collapse.				
<div> <div> *Specialty <div></div> </div> <div> *Effective Date <div></div> </div> <div> *Taxonomy <div></div> </div> </div> <div> <div>Provider Type Physician</div> <div>End Date <div></div> </div> <div>Primary <input checked="" type="checkbox"/></div> </div> <div> Add Reset </div>				

### Additional Taxonomies

Fields marked "required" in this section are only required if any information is entered in this section. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

Taxonomy	Action
<input type="checkbox"/> Click to collapse.	
<div> *Taxonomy <div></div> </div>	
Add	

Continue
Finish Later
Cancel

The specialties that will be available on this panel are based on the Enrollment Type and Provider Type selection made on the Request Information screen. At least one specialty is required. Some provider types only allow for one specialty, and some provider types allow for multiple specialties. However, only one specialty can be designated as the primary specialty. The system will only accept certain specialties.

Please see the 'Provider Type, Enrollment Type and Enrollment' section of this document for additional information on provider types, enrollment types, and specialties.

A Taxonomy code must be provided for each specialty, except for when "Atypical" is selected as the Enrollment Type.

## Specialties Section

**Specialties**

The provider type is established on the Request Information screen. All specialties available for the selected provider type can be added on this screen.

\* Indicates a required field.  
 ✓ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

	Specialty	Taxonomy	Effective Date	End Date	Action
[-]	Click to collapse.				
[+]	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>*Specialty <span style="border: 1px solid black; padding: 2px;">▼</span></p> <p>*Effective Date <span style="border: 1px solid black; padding: 2px;">Physician</span></p> <p>*Taxonomy <span style="border: 1px solid black; padding: 2px;">▼</span></p> </div> <div style="width: 50%;"> <p>Provider Type Physician</p> <p>End Date <span style="border: 1px solid black; padding: 2px;">📅</span></p> <p>Primary <input checked="" type="checkbox"/></p> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <span>Add</span> <span>Reset</span> </div>				

**Specialty** – Use the drop-down box to select "Specialty". The specialty entered here will drive the choices available under the "Taxonomy" drop-down.

**Note:** There are many instances where the only "Specialty" option is the "Provider Type" chosen. If this is the case, select the only option available and then use the "Taxonomy" drop-down to indicate the area of specialty.

**Example:** If the enrolling provider is a Pediatrician, select the only option shown (Physician) as the specialty, and then choose Pediatrics in the "Taxonomy" drop-down.

**Effective Date** – Enter the effective date of the specialty. This selection can be done by clicking the calendar icon next to the date field. The calendar icon is shown here. 📅 This is a required field.

**End Date** – Enter the End date, if appropriate, for the specialty. This selection can be done by clicking the calendar icon next to the date field. The calendar icon is shown here. 📅 This is not a required field.

## Specialties Section – Taxonomy Code

**Provider Enrollment: Specialties**

[Welcome](#)  
[Request Information](#)  
**Specialties**  
[Addresses](#)  
[Provider Identification](#)  
[Network Participation](#)  
[Languages](#)  
[EFT Enrollment](#)  
[Other Information](#)  
[Addendums](#)  
[Disclosures](#)  
[Attachments and Fees](#)  
[Agreement](#)  
[Summary](#)

**Specialties**  
The provider type is established on the Request Information screen. All specialties available for the selected provider type can be added on this screen.

\* Indicates a required field.  
✓ Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

Specialty	Taxonomy	Effective Date	End Date	Action
Click to collapse.				
*Specialty	Physician	01/01/2020	End Date	Provider Type Physician
*Specialty Effective Date				
*Taxonomy	<div> <div>Independent Medical Examiner</div> <div>Phlebology</div> <div>Neuromusculoskeletal Medicine - Sports Medicine</div> <div>Neuromusculoskeletal Medicine OMM</div> <div>Oral Maxillofacial Surgery</div> <div>Transplant Surgery</div> <div>Electrodiagnostic Medicine</div> <div>Allergy Immunology</div> <div>Allergy Immunology - Allergy</div> <div>Allergy Immunology - Clinical Laboratory Immunology</div> <div>Anesthesiology</div> <div>Anesthesiology - Addiction Medicine</div> <div>Anesthesiology - Critical Care Medicine</div> <div>Anesthesiology - Hospice and Palliative Medicine</div> <div>Anesthesiology - Pain Medicine</div> <div>Anesthesiology - Pediatric Anesthesiology</div> <div>Dermatology</div> <div>Dermatology - MOHS-Micrographic Surgery</div> <div>Dermatology - Dermatopathology</div> <div>Dermatology - Clinical Laboratory Dermatological Immunology</div> <div>Dermatology - Pediatric Dermatology</div> <div>Dermatology - Procedural Dermatology</div> <div>Emergency Medicine</div> <div>Emergency Medicine - Emergency Medical Services</div> <div>Emergency Medicine - Undersea and Hyperbaric Medicine</div> <div>Emergency Medicine - Hospice and Palliative Medicine</div> <div>Emergency Medicine - Pediatric Emergency Medicine</div> <div>Emergency Medicine - Sports Medicine</div> <div>Emergency Medicine - Medical Toxicology</div> </div>			
<div> <div>Click to collapse.</div> <div>Taxonomy</div> <div>Add</div> </div>				

**Additional Taxonomy**  
Fields marked required  
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

05.00.364

**Taxonomy** – Select a taxonomy (specialization) that is associated with the provider. This selection is accessed via the drop-down. This is a required field.

**Primary** – Only one specialty can be designated as the primary specialty.

At least one taxonomy entered must match to one taxonomy listed in the National Provider Identifier NPI registry.

Don't forget to click the **Add** button!



## Additional Taxonomies Section

**Additional Taxonomies**

Fields marked required in this section are only required if any information is entered in this section. Click "\*" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" link to remove the entire row.

Taxonomy
<input type="checkbox"/> Click to collapse.
*Taxonomy <input type="text"/>
<input type="button" value="Add"/>

**Additional Taxonomies are NOT required. Simply press the continue button if the user does not want to add additional taxonomy codes.**

**Taxonomy** – Select an additional taxonomy code **if desired**. This is an alphanumeric look-up search field that responds to the characters entered into the field to return a list of valid taxonomy codes. Enter 2 or more characters to begin a search then select an entry from the list that is shown.

This panel is complete, select **"Continue"**, **"Finish Later"**, or **"Cancel"**.

## Addresses Panel

Provider Enrollment: Addresses <span>?</span>																																
<a href="#">Welcome</a>	* Indicates a required field.																															
<a href="#">Request Information</a>	<b>Provider Addresses</b>																															
<a href="#">Change of Ownership</a>	The provider addresses identify the location where a provider renders services, as well as locations that are used for billing and payment.																															
<a href="#">Specialties</a>	All Providers must enter a Service Location, Billing, and Mailing address.																															
<b>Addresses</b>	The Service Location Address Office Phone number is public facing and will be printed on member documentation.																															
Provider Identification	Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the <b>"Add"</b> button. Click <b>"Remove"</b> to remove the entire row.																															
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All providers regardless of enrollment type are required to enter three different address types: Service Location, Mailing and Billing.

There are slight differences in the information collected for each address type.

Please see the 'Provider Type, Enrollment Type and Enrollment' section of this document for additional information on these address types.

**NOTE:** Business entities (enrolling with a federal employer identification number) must complete a separate enrollment application for each service location address.

Individuals (enrolling with a Social Security Number) are limited to one enrollment only.



**Provider Addresses Section**

To begin, select the address type from the Address Type drop-down. Complete the fields displayed. A description of each field is provided below.

When the address type “Service Location” is selected, an additional section will display in the panel. See example below.

### ***Adding Service Location Address Information***

Provider Enrollment - Addresses																																																												
<a href="#">Welcome</a> <a href="#">Request Information</a> <a href="#">Change of Ownership</a> <a href="#">Specialties</a> <b>Addresses</b> Provider Identification Network Participation Languages EFT Enrollment Other Information Addendums Disclosures Attachments and Fees Agreement Summary	<p>* Indicates a required field.</p> <h3>Provider Addresses</h3> <p>The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.</p> <p>The service location address must be a physical location. A post office box is not a valid service location address.</p> <p>The service location address must include an <b>office</b> phone number and at least one <b>email</b> address. It is desired that the service location address provide a <b>fax</b> phone number.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the <b>"Add"</b> button. Click <b>"Remove"</b> to remove the entire row.</p> <table border="1"> <thead> <tr> <th>Type</th> <th>Address</th> <th>City</th> <th>State</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="5"> <input type="checkbox"/> Click to collapse.               </td> </tr> <tr> <td>* Address Type</td> <td>Service Location</td> <td></td> <td></td> <td></td> </tr> <tr> <td>* Location Code</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>* Address</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>* City</td> <td></td> <td>County</td> <td></td> <td></td> </tr> <tr> <td>* State</td> <td>Colorado</td> <td>* Zip Code</td> <td></td> <td></td> </tr> <tr> <td>Primary Email</td> <td></td> <td>Confirm Email</td> <td></td> <td></td> </tr> <tr> <td>Secondary Email</td> <td></td> <td>Confirm Email</td> <td></td> <td></td> </tr> <tr> <td>Phone</td> <td></td> <td>Ext</td> <td></td> <td></td> </tr> <tr> <td>Phone</td> <td></td> <td>Ext</td> <td></td> <td></td> </tr> </tbody> </table> <p><b>"Primary Email" and "Phone" are required for all providers (even though there is a "Fax" field).</b></p> <h3>Service Address Information</h3> <p>If 'Address Type' is changed from 'Service', the service information below will be lost upon Add or Save of address.</p> <p>Opt Out of Provider Directory <input type="checkbox"/></p> <p>Accepting New Members <input type="checkbox"/>      ADA Compliant <input type="checkbox"/>      Accepting New Members with Special Needs <input type="checkbox"/></p> <p>TDD Capability <input type="checkbox"/>      Phone <input type="text"/>      Ext <input type="text"/></p> <p>TTY Capability <input type="checkbox"/>      Phone <input type="text"/>      Ext <input type="text"/></p> <p> <input type="button" value="Add"/> <input type="button" value="Reset"/> </p>					Type	Address	City	State	Action	<input type="checkbox"/> Click to collapse.					* Address Type	Service Location				* Location Code					* Address					* City		County			* State	Colorado	* Zip Code			Primary Email		Confirm Email			Secondary Email		Confirm Email			Phone		Ext			Phone		Ext		
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**Address Type** – Use the drop-down to select the “Service Location”. This will immediately open the “Service Address Information” panel at the bottom of the screen. This is a required field.

**Location Code** – Use this drop-down to indicate the address location in relation to the State of Colorado. Possible selections are Border Provider, In-State, and Out-of-State. This is a required field.

**Note:** To see a list of approved Border Providers click the “?” Help button on the upper right corner on this panel.

- Users may also visit the [Billing Manuals web page](#) and reference Appendix F under the [Appendices drop-down](#) for a list of approved border cities/town by bordering state.
- Visit the [Information by Provider Type web page](#), select the appropriate provider type drop-down and refer to the “BT Allowed?” field in the table (see example below) to determine if your provider type allows enrollment when the service location is in an approved border town.

Risk Level:	Limited	Fee Req'd?	No	NPI Req'd?	No
Medicare Req'd?	No	OOS Allowed?	Yes	BT Allowed?	Yes

**Address** – Enter the street address of the location. (The Service Location must be a physical address and cannot be a PO Box.) This address can be two lines, if needed. Suite numbers, building or unit numbers should be submitted on the 2<sup>nd</sup> line. This field allows up to 55 alphanumeric characters. This is a required field.

**City** – Enter the appropriate city or town for this location. This field allows up to 30 alphanumeric characters. This is a required field.

**County** – Enter the appropriate county for this location. This field allows up to 30 alphanumeric characters. This is not a required field. Do not select “State of Colorado” as the County.

**State** – A drop-down of the valid state options that a provider may select for an address. This defaults to Colorado. This is a required field.

**Zip Code** – Enter the 9-digit zip code for this location. This is a required field.

**Primary Email** – Enter the primary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is a required field.

**Confirm Primary Email Address** – Re-enter the primary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is a required field.

**Secondary Email** – Enter the secondary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is not a required field.

**Confirm Secondary Email Address** – Re-enter the secondary email address associated with the provider. This field allows up to 50 alphanumeric characters. Enter email with 'name@domain' format. This is not a required field unless the Secondary Email Address field is completed.

**Phone (Type 1 of 4)** – Use the drop-down and select the **Office** phone number type. **At least one “Office” number is required per location.**

**Phone (1 of 4)** – Enter the 10-digit office phone number associated to the location. This is a required field. The Service Location Address Office Phone number is public facing and will be printed on member documentation.

**Ext (1 to 4)** – When applicable, enter the extension for the office phone number associated to the location. This is not a required field.

**Phone (Type 2 through 4)** – For additional phone numbers, use the drop-down to select the type of phone number being entered. Available selections are Cell, Fax, Office, Toll Free, and Other. These are not required fields.

**Phone (2 through 4)** – When applicable, enter additional 10-digit phone numbers associated to the location and phone type indicated. These are not required fields.

**Ext (2 through 4)** – Enter extensions applicable to the additional phone numbers entered. These are not required fields.

### Service Address Information

These fields only display on the Service Location address panel.

**Opt Out of Provider Directory** – Use this check box to indicate whether the Service Location should be omitted from the provider directory. Leaving this field blank will include the location in the provider directory. This field is not required.

**Accepting New Members** – Use this check box to indicate if the Service Location is accepting new patients. This field is not required, however leaving the field blank will indicate that the location is not accepting new patients.

**ADA Compliant** – Use this check box to indicate if the Service Location is compliant with the American Disabilities Act (ADA). This field is not required; however, leaving the field blank will indicate that the location is not compliant.

**Accepting New Members with Special Needs** – Use this check box to indicate if the Service Location is accepting new patients with special needs. This field is not required; however, leaving the field blank will indicate that the location is not accepting new patients with special needs.

**TDD Capability** – Use this check box to indicate if the service location provides a telephone device for the deaf (TDD). This field is not required; however, leaving the field blank will indicate that the location does not offer TDD capability.

**Phone (TDD)** – Use this field to enter the 10-digit phone number associated with the TDD capability. This field is only required if the TDD Capability box is checked.

**Ext (TDD)** – Use this field to enter the 4-digit extension associated with the TDD if applicable. This field is not required.

**TTY Capability** – Use this check box to indicate if the service location provides a telephone typewriter for the deaf (TTY). This field is not required; however, leaving the field blank will indicate that the location does not offer TTY capability.

**Phone (TTY)** – Use this field to enter the 10-digit phone number associated with the TTY capability. This field is only required if the TTY Capability box is checked.

**Ext (TTY)** – Use this field to enter the 4-digit extension associated with the TTY if applicable. This field is not required.

After entering the appropriate information on this panel, click the **“Add”** button. This will store the information in the application. This does not save the information until either the **“Finish Later”** button is clicked, or the application is submitted at the end of the process. After the **“Add”** button is clicked, the panel will update to the version below.

### Provider Addresses Section – Service Location Added

Provider Enrollment: Addresses																							
<a href="#">Welcome</a>	* Indicates a required field.																						
<a href="#">Request Information</a>	<b>Provider Addresses</b>																						
<a href="#">Change of Ownership</a>	The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.																						
<a href="#">Specialties</a>	The service location address must be a physical location. A post office box is not a valid service location address.																						
<b>Addresses</b>	The service location address must include an <b>office</b> phone number and at least one <b>email</b> address. It is desired that the service location address provide a <b>fax</b> phone number.																						
Provider Identification	Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the <b>"Add"</b> button. Click <b>"Remove"</b> to remove the entire row.																						
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	Type	Address	City	State	Action																		
<input type="checkbox"/>	Service Location	1 Any Street	Denver	Colorado	<a href="#">Copy</a> <a href="#">Remove</a>																		
<input type="checkbox"/>	Click to add address.																						
Languages																							
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Other Information																							
Addendums																							
Disclosures																							
Attachments and Fees	<div> <a href="#">Continue</a> <a href="#">Finish Later</a> <a href="#">Cancel</a> </div>																						
Agreement																							
Summary																							

Click the "+" symbol located beside the words **"Click to add address"** to begin the process to add the next address. Click **"Copy"** if the next address is the same, then edit as needed. The **"Copy"** feature is helpful when two or more addresses are the same.

### Provider Addresses Section - Add another Address

	Type	Address	City	State	Action
<input type="checkbox"/>	Service Location	1 Any Street	Denver	Colorado	<a href="#">Copy</a> <a href="#">Remove</a>
<input type="checkbox"/>	Click to add address.				

To add a Billing address or Mailing address select **"Billing"** or **"Mailing"** in the Address Type field and complete the remaining information. There is one additional field when the Billing or Mailing address panels are displayed.

**Pay To Name or Mail To Name** – Enter the person, area or entity to identify where billing or mailed information should be sent (e.g. Office Manager, Billing Manager, Front Desk, Mail Room, etc.) These are required fields.

*Address Type	<input type="text" value="Billing"/>
*Location Code	<input type="text" value="In-State"/>
*Pay To Name	<input type="text" value="Bob"/>

To delete an entire row, click the **“Remove”** button located in the **“Action”** field. This will delete the entire row. Once deleted the row must be re-entered.

### *Provider Addresses Panel – Completed*

Provider Enrollment: Addresses																													
<a href="#">Welcome</a>	* Indicates a required field.																												
<a href="#">Request Information</a>	<b>Provider Addresses</b>																												
<a href="#">Change of Ownership</a>	The provider addresses identify the location where a provider renders services, as well as locations that are used for billing and payment.																												
<a href="#">Specialties</a>	All Providers must enter a Service Location, Billing, and Mailing address.																												
<b>Addresses</b>	The Service Location Address Office Phone number is public facing and will be printed on member documentation.																												
Provider Identification	Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the <b>“Add”</b> button. Click <b>“Remove”</b> to remove the entire row.																												
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Languages	You have reached the maximum number of addresses allowed for this list.																												
EFT Enrollment	<div> <a href="#">Continue</a> <a href="#">Finish Later</a> <a href="#">Cancel</a> </div>																												
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When all three addresses are entered, select **“Continue”**, **“Finish Later”**, or **“Cancel”**.

## Provider Identification Panel

The example below displays a Group enrollment type. The panel may look similar to the following. See additional examples below.

Provider Enrollment: Provider Identification																																				
<a href="#">Welcome</a>	* Indicates a required field.																																			
<a href="#">Request Information</a>	<b>Provider Legal Name</b>																																			
<a href="#">Change of Ownership</a>	The provider legal name and information is provided once for each enrollment.																																			
<a href="#">Specialties</a>	*Provider Legal Name <input type="text"/>																																			
<a href="#">Addresses</a>	Doing Business As <input type="text"/>																																			
<b>Provider Identification</b>	<b>Organizational Structure</b>																																			
Network Participation	Select the applicable type of business.																																			
Languages	*Organization Type <input type="text"/>																																			
EFT Enrollment	<b>Payer</b>																																			
Other Information	Select at least one payer. Providers will be required to view and electronically sign a Provider Participation Agreement (PPA) specific to each payer selected.																																			
Addendums	*Payer <input type="checkbox"/> Colorado BHA																																			
Disclosures	<input type="checkbox"/> Title XIX Payer																																			
Attachments and Fees	<b>License</b>																																			
Agreement	Primary license data must be entered if required for the selected provider type and specialties. Non-required licenses may be added and indicated as secondary. Click <a href="#">here</a> to search for a Colorado Department of Regulatory Agencies (DORA) license.																																			
Summary	Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.																																			
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	Enter Certification information if applicable. If certified, please provide the specialty certification number, effective date, and expiration date of certification.																																			
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Specialty	Certificate Number	Certification Type	Effective Date	End Date	Action																															
<input type="checkbox"/> Click to add certification.																																				
	<b>Medicare Participation</b>																																			
	To receive Medical Assistance Program payments for services provided to individuals who have Medicare and Medical Assistance Program benefits, providers must accept assignment of their Medicare claims.																																			
	Automatic crossover is an exchange of claim information between Medicare and the Medical Assistance Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Medical Assistance Program. The Colorado Medical Assistance Program obtains crossover claim information from Colorado Medicare carriers and intermediaries. For automatic crossover to occur, providers must identify their NPI number.																																			
	Automatic crossovers should occur when the participant has registered their NPI with Medicare Part A and/or Part B and in the Colorado interChange.																																			
	Medicare numbers are no longer used for automatic crossover from Medicare Part A and Part B to the Medical Assistance Program.																																			
	Medicare # <input type="text"/> Effective Date <input type="text"/> Medicare Type <input type="text"/>																																			
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>																																			

The Provider Identification panel requests information such as the legal name, a group practice or facility information, school information, and any appropriate identification numbers, such as U.S. Drug Enforcement Administration (DEA), state license numbers, and Medicare numbers. Please note that the Provider Enrollment Tool will present the user with the identification fields that are appropriate to the provider type, based on the previous selections. For example, an individual will be presented with fields to identify their education; however, a Facility application will not include these fields.

Below is a comprehensive list of all the Provider Identification fields that could be present:

### **Provider Legal Name Section**

#### ***Group, Atypical or Facility Providers***

**Provider Legal Name** – Enter the Provider Legal Name for a group, atypical provider, or facility. This field allows up to 70 alphanumeric characters. This is a required field.

**Doing Business As** – Enter the Doing Business As name of the provider, if applicable. This field allows up to 30 alphanumeric characters. This is not a required field.

#### ***Individual Providers***

**Last Name** – Enter the last name for an individual provider. This field allows up to 60 Alphanumeric characters. This is a required field.

**First Name** – Enter the first name field for an individual provider. This field allows up to 25 alphanumeric characters. This is a required field.

**Middle** – Enter the Middle Initial associated to the middle name of the Provider. This field allows one letter.

**Suffix** – Enter the Suffix field for an individual provider, if applicable. This field allows up to ten alphanumeric characters. This field should be used to indicate MD, PhD, etc.

### **Organizational Structure Section or Individual Provider Section**

#### ***Organizational Structure Section***

**Organization Type** – Select the Organization type for the enrolling entity from the drop-down. Typical values could include: Corporation, Estate, Trust, etc. If the user is unsure of the organization type the user may be able to find this information by [performing a records search on the Secretary of State website](#).

#### ***Individual Providers Section***

**Gender** – Select the gender associated with an individual provider from the drop-down. This is a required field.

**Birth Date** – Enter the birth date associated with the individual provider. This field allows eight numeric characters. This field is only displayed if the enrollment type is 'Individual within a Group', 'Ordering, Prescribing, Referring' (OPR) or 'Billing Individual'. The Birth Date must be between 0 and 150 years old. This must be entered as a valid value in the format 'MM/DD/YYYY'.

**Degree** – Select the appropriate professional degree received by the individual provider from the drop-down. Degree is a required field if any one of the "Professional Education fields" is entered.



**School** – Enter the Name of school from which the degree was received by the individual provider. This field allows up to 25 alphanumeric characters. School Name is a required field if any one of the Professional Education fields is entered.

**Year of Graduation** – Enter the year in which the provider obtained the degree. This field allows up to four numeric characters. Year of Graduation is a required field if any one of the Professional Education fields is entered. Year of Graduation cannot be more than 125 years in the past. Year of Graduation cannot be in the future.

### Payer Section

**Payer** – Select the appropriate Payer. Applicable Payer checkboxes will be enabled and at least one Payer must be selected.

### License Section

If the license is a Colorado Department of Regulatory Agencies (DORA), an automatic lookup will be performed when the Issuing Authority and License # are entered. If a match is found in DORA, the Effective Date, Expiration Date, and Issuing State will be retrieved and populated automatically.

**Issuing Authority** – Select the agency that issued the license. [Examples: Colorado Department of Regulatory Agencies (DORA), Colorado Department of Public Health & Environment (CDPHE)]. Issuing Authority is a required field if any one of the other License fields is entered.

**License #** – Enter the entire License Number including alphanumeric, dots, dashes, etc. This field allows up to 20 characters. License Number is a required field if any one of the other License fields is entered. Each license that is listed in the application must have a corresponding attachment for verification, showing the license number, the effective date and the expiration date of the license.

**Effective Date (License)** – Enter the effective date for the license number assigned to the provider. Be sure to enter the effective date and not the issue date. This field allows eight numeric characters. The Effective Date is a required field if one of the other License fields is entered. This must be entered as a valid value in the format 'MM/DD/YYYY'.

**Expiration Date (License)** – Enter the expiration date for the license number assigned to the provider. This field allows eight numeric characters. The Expiration Date is a required field if one of the other License fields is entered. The Expiration Date cannot be before the Effective Date. This must be entered as a valid value in the format 'MM/DD/YYYY'.

**Issuing State** – Select the State the license is issued from using the drop-down. Issuing State is a required field if any one of the other License fields is entered.

**Description** – Optional license description. This free form field allows up to 50 characters.

**Type** – Select the appropriate value for the license type. Valid values are Primary or Secondary. Type is a required field if any one of the other License fields is entered. Provider types or specialties that require a license must add required licenses with a Type of Primary. Visit the [Information by Provider Type web page](#), click on the Provider Type drop-down and reference the Required Attachments for more information on required licenses. Non-required licenses may be added with a Type of Secondary.

### Certification Section

**Specialty** – Select the Specialty from the drop-down. Typical values could include: Physician, Pharmacy, Nursing Facility, etc. This field is required.


**Certificate Number** - Enter the Certification number. This field allows 20 alphanumeric characters. This field is required.

**Certification Type** – Select the appropriate Certification Type from the drop-down. Values could include: Accreditation, National Specialty Board, Other, Tax Exempt, etc. This field is required.

**Effective Date** – Enter the Effective date for the certification. This field allows eight numeric characters in MM/DD/YYYY format. This is a required field if the certificate number is entered.

**End Date** – Enter the End date for the certification. This field allows eight numeric characters in MM/DD/YYYY format. End Date cannot be before Effective Date. This field is required.



Select the  button to add the certificate information. If additional certifications need to be entered, click '+' to add certificates:

Certification						
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.						
Enter Certification information if applicable. If certified, please provide the specialty certification number, effective date, and expiration date of certification.						
	Specialty	Certificate Number	Certification Type	Effective Date	End Date	Action
	Clinic - Practitioner	AA123	Other	01/01/2023	12/31/2023	<a href="#">Remove</a>
	Click to add certification.					

### Medicare Participation Section

**Medicare #** – Enter the Medicare Number assigned by the Federal government to the provider. This field allows ten alphanumeric characters. Medicare Number is a required field if any one of the other Medicare fields is entered.

**Effective Date (Medicare Number)** – Enter the effective date of the Medicare Number. This is the date the Medicare contractor received the signed and dated Certification Statement. This field allows eight numeric characters. The Effective Date is a required field if one of the other Medicare fields is entered. This must be entered as a valid value in the format 'MM/DD/YYYY'.

**Medicare Type** – Select the Medicare Type associated with the Medicare Number from the drop-down. Medicare Type is required if any one of the other Medicare fields is entered. Typical values could include Medicare Part A, Medicare Part B, etc.

### CLIA Certification Section or DEA Section

#### CLIA Certification Section

**CLIA #** – For Group, Facility or Atypical providers, enter the Clinical Laboratory Improvement Amendment (CLIA) certification number assigned to the provider. The field allows up to ten numeric characters. CLIA # is a required field if any CLIA field is entered. A copy of the CLIA certificate is required in attachments. The CLIA data panel should not be displayed in applications for individuals.

**Effective Date (CLIA)** – Enter the effective date for the CLIA certification number. Effective Date is a required field if a CLIA # is entered. This field allows eight Numeric characters. This must be entered as a valid value in the format 'MM/DD/YYYY'.

**End Date (CLIA)** – Enter the end date for the CLIA certification number. If there is no end date for the CLIA certification, enter 12/31/2299. This field allows eight numeric characters. The End Date is a required field if one of the other CLIA fields is entered. This must be entered as a valid value in the format 'MM/DD/YYYY'.

### ***DEA Section***

**DEA #** – Enter the DEA (Drug Enforcement Agency) number that is assigned to the provider. This field allows nine alphanumeric characters. DEA Number is required if Effective Date is entered.

**Effective Date (DEA)** – Enter the effective date for the DEA Number. Effective Date is a required field if a DEA Number is entered. This field allows eight Numeric characters. This must be entered as a valid value in the format 'MM/DD/YYYY'.

### **Other Identifier(s)**

#### ***Managed Care Organizations***

**Health Plan Identifier (HPID)** – Enter the Health Plan ID for the provider. The HPID is only for Managed Care Organizations. This field allows up to 15 alphanumeric characters.

#### ***Pharmacy Enrollments***

**NCPDP Provider ID Number** – Enter the NCPDP Provider ID Number of the provider. This field allows the ten alphanumeric characters. This is an optional field and is applicable to Pharmacy enrollments only.

**Pharmacy Classification** – Enter the classification of the Pharmacy ID. List includes values such as Chain, Federal Government, Hospital, etc.

When the panel is complete, select “**Continue**”, “**Finish Later**”, or “**Cancel**”.

## Billing Individuals, Individual within Group, and OPR

This is an example of the panel for an Individual within Group Provider Type selection.

### *Provider Identification Panel – Individual within Group*

**Provider Enrollment: Provider Identification**

Welcome \* Indicates a required field.

**Request Information**

**Specialties**

**Addresses**

**Provider Identification**

**Network Participation**

**Languages**

**EFT Enrollment**

**Other Information**

**Addendums**

**Disclosures**

**Attachments and Fees**

**Agreement**

**Summary**

**Provider Legal Name**

The provider legal name and information is provided once for each enrollment.

\*Last Name

\*First Name

Middle  Suffix

Doing Business As

**Individual Providers**

\*Gender  \*Birth Date

Fields marked required in this section are only required if any information is entered in this section. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

Degree	School	Year of Graduation	Action
Click to collapse.			
*Degree <input type="text"/>	*School <input type="text"/>	*Year of Graduation <input type="text"/>	
Add Reset			

**Payer**

Select at least one payer. Providers will be required to view and electronically sign a Provider Participation Agreement (PPA) specific to each payer selected.

\*Payer  Colorado BHA ☐ Title XIX Payer ☐

**License**

Primary license data must be entered if required for the selected provider type and specialties. Non-required licenses may be added and indicated as secondary. Click [here](#) to search for a Colorado Department of Regulatory Agencies (DORA) license. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

License #	Effective Date	Expiration Date	Issuing State	Action
Click to collapse.				
Enter the entire license ID including alpha, numeric, dots, dashes, etc. The license record must be effective prior to or as of 04/24/2023. If the Issuing Authority is the Colorado Department of Regulatory Agencies (DORA), an automatic license look up will be performed. If a matching license record is found, the data will be returned for review. If no matching license record is found, manually enter the license information.				
*Issuing Authority <input type="text"/>	*Effective Date <input type="text"/>	*License # <input type="text"/>	*Expiration Date <input type="text"/>	
*Issuing State <input type="text"/>	Description <input type="text"/>			
*Type <input type="text"/>				
Add Reset				

**Certification**

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

Enter Certification information if applicable. If certified, please provide the specialty certification number, effective date, and expiration date of certification.

Specialty	Certificate Number	Certification Type	Effective Date	End Date	Action
Click to collapse.					
Physician	ABC123	Accreditation	01/01/2023	12/31/2023	Remove
Click to add certification.					

**Medicare Participation**

To receive Medical Assistance Program payments for services provided to individuals who have Medicare and Medical Assistance Program benefits, providers must accept assignment of their Medicare claims.

Automatic crossover is an exchange of claim information between Medicare and the Medical Assistance Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Medical Assistance Program. The Colorado Medical Assistance Program obtains crossover claim information from Colorado Medicare carriers and intermediaries. For automatic crossover to occur, providers must identify their NPI number.

Automatic crossovers should occur when the participant has registered their NPI with Medicare Part A and/or Part B in the Colorado interChange.

Medicare numbers are no longer used for automatic crossover from Medicare Part A and Part B to the Medical Assistance Program.

Medicare #  Effective Date  Medicare Type

**CLIA Certification**

Fields marked required in this section are only required if any information is entered in this section. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row. If a CLIA certificate is not required for the provider type and/or not applicable because testing is not performed at this location, then the information below may be left blank.

CLIA #	Effective Date	End Date	Action
Click to collapse.			
*CLIA # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
Add Reset			

**DEA #**

When changing your DEA #, supporting documentation is required as an attachment to this request. Fields marked required in this section are only required if any information is entered in this section. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

DEA #	Effective Date	End Date	Action
Click to collapse.			
*DEA # <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
Add Reset			

Continue Finish Later Cancel

Fields marked required in this section are only required if any information is entered in this section.

A license may be required depending on the Provider Type and/or Specialty selected.

## Facility and Atypical

This is an example of the panel for an Atypical Provider Type selection.

### *Provider Identification Panel – Atypical*

**Provider Enrollment: Provider Identification** ?

[Welcome](#) | [Request Information](#) | [Change of Ownership](#) | [Specialties](#) | [Addresses](#) | **Provider Identification** | [Network Participation](#) | [Languages](#) | [EFT Enrollment](#) | [Other Information](#) | [Addendums](#) | [Disclosures](#) | [Attachments and Fees](#) | [Agreement](#) | [Summary](#)

\* Indicates a required field.

**Provider Legal Name**

The provider legal name and information is provided once for each enrollment.

\*Provider Legal Name

Doing Business As

**Organizational Structure**

Select the applicable type of business.

\*Organization Type

**Payer**

Select at least one payer. Providers will be required to view and electronically sign a Provider Participation Agreement (PPA) specific to each payer selected.

\*Payer ☐ Colorado BHA ☐ Title XIX Payer

**License**

Primary license data must be entered if required for the selected provider type and specialties. Non-required licenses may be added and indicated as secondary. Click [here](#) to search for a Colorado Department of Regulatory Agencies (DORA) license. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

License #	Effective Date	Expiration Date	Issuing State	Action
<input type="checkbox"/> Click to collapse.				
Enter the entire license ID including alpha, numeric, dots, dashes, etc. The license record must be effective prior to or as of 08/02/2023. If the Issuing Authority is the Colorado Department of Regulatory Agencies (DORA), an automatic license look up will be performed. If a matching license record is found, the data will be returned for review. If no matching license record is found, manually enter the license information.				
*Issuing Authority <input type="text"/>	*Effective Date <input type="text"/>	*License # <input type="text"/>	*Expiration Date <input type="text"/>	Description <input type="text"/>
*Issuing State <input type="text"/>	*Type <input type="text"/>			
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

**Certification**

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

Enter Certification information if applicable. If certified, please provide the specialty certification number, effective date, and expiration date of certification.

Specialty	Certificate Number	Certification Type	Effective Date	End Date	Action
<input type="checkbox"/> Click to collapse.					
*Specialty <input type="text"/>	*Certificate Number <input type="text"/>	*Certification Type <input type="text"/>	*Effective Date <input type="text"/>	*End Date <input type="text"/>	
<input type="button" value="Add"/> <input type="button" value="Reset"/>					

**Medicare Participation**

To receive Medical Assistance Program payments for services provided to individuals who have Medicare and Medical Assistance Program benefits, providers must accept assignment of their Medicare claims.

Automatic crossover is an exchange of claim information between Medicare and the Medical Assistance Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Medical Assistance Program. The Colorado Medical Assistance Program obtains crossover claim information from Colorado Medicare carriers and intermediaries. For automatic crossover to occur, providers must identify their NPI number.

Automatic crossovers should occur when the participant has registered their NPI with Medicare Part A and/or Part B and in the Colorado interChange.

Medicare numbers are no longer used for automatic crossover from Medicare Part A and Part B to the Medical Assistance Program.

Medicare #  Effective Date  Medicare Type

If the user is unsure of the organization type the user may be able to find this information by performing a records search on the [Secretary of State website](#).

A license may be required depending on the Provider Type and/or Specialty selected.

## Network Participation Panel

**COL Department Policy 8**

**Health First COLORADO**  
Colorado's Medicaid Program  
[Contact Us](#) | [Login](#)

Home > [Provider Enrollment](#) > Network Part

**Provider Enrollment: Network Particip**

Welcome  
[Request Information](#)  
[Change of Ownership](#)  
[Specialties](#)  
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**Network Participation**  
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Summary

**Managed Care Network**  
\* Indicates a required  
Documentation confirm  
Fees step of enrollmen  
Fields marked required  
Click "+" to view or up  
required fields and clic

Click to collapse.

**\*Network**

[Add](#)

CHP+ - Denver Health Medical Plan Inc.  
CHP+ - Friday Health Plans  
CHP+ - Kaiser Permanente  
CHP+ - Rocky Mountain HMO Inc.  
INACTIVE - ACC: Access Kaiser  
INACTIVE - Access Behavioral Care Denver  
INACTIVE - Access Behavioral Care Northeast  
INACTIVE - Behavioral Healthcare Inc.  
INACTIVE - CHP+ - Delta Dental Plan of CO  
INACTIVE - Colorado Health Networks  
INACTIVE - Foothills Behavioral Health Partner  
MCO - Denver Health Medical Choice  
MCO - Rocky Mountain Health Plans Prime  
MCO - Total Longterm Care Pueblo (PACE)  
MCO - TRU Community Care (PACE)  
PACE - InnovAge /Total Longterm Care Aurora  
PACE - InnovAge /Total Longterm Care Denver  
PACE - InnovAge /Total Longterm Care Lakewood  
PACE - InnovAge /Total Longterm Care Loveland  
PACE - InnovAge /Total Longterm Care Thornton  
PACE - Rocky Mountain Health Care Services  
PACE - Senior Community Care  
RAE - (Region 1) Rocky Mountain Health Plans  
RAE - (Region 2) Northeast Health Partners  
RAE - (Region 3) Colorado Access  
RAE - (Region 4) Health Colorado, Inc.  
RAE - (Region 5) Colorado Access  
RAE - (Region 6) Colorado Community Health Allianc  
RAE - (Region 7) Colorado Community Health Allianc  
Colorado Access Behavioral Health for DHMC

Effective Date Action

[Continue](#) [Finish Later](#) [Cancel](#)

R05.00.321 [Privacy Notice](#)

INTRUST SECURED SSL

### Selection for PACE-Only Subcontractors

**Provider Identification**

**Network Participation**  
Languages  
Attachments and Fees  
Summary

Click to collapse.

**\*Network**

[Add](#)

PACE Organization Effective Date Action

MCO - Total Longterm Care Pueblo (PACE)  
MCO - TRU Community Care (PACE)  
PACE - HopeWest  
PACE - InnovAge /Total Longterm Care Aurora  
PACE - InnovAge /Total Longterm Care Denver  
PACE - InnovAge /Total Longterm Care Lakewood  
PACE - InnovAge /Total Longterm Care Loveland  
PACE - InnovAge /Total Longterm Care Thornton  
PACE - Rocky Mountain Health Care Services  
PACE - Senior Community Care

[Finish Later](#) [Cancel](#)

R05.00.308



**Provider Enrollment: Network Participation**

[Welcome](#)

[Request Information](#)

[Change of Ownership](#)

[Specialties](#)

[Addresses](#)

[Provider Identification](#)

**Network Participation**

[Languages](#)

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**Managed Care Network Participation**

\* Indicates a required field.

Documentation confirming your participation in a MCO/BHO network will be required on the Attachments and Fees step of enrollment.

Fields marked required in this section are only required if any information is entered in this section. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

	Managed Care Network	Effective Date	Action
<input type="checkbox"/>	Colorado Access Behavioral Health for DHMC	01/01/2021	<a href="#">Remove</a>
<input type="checkbox"/>	Click to add Managed Care Network		

[Continue](#) [Finish Later](#) [Cancel](#)

The Network Participation panel is where providers may enter any medical networks that they participate in. Adding a network option here will not create an enrollment into that network. Additionally, a copy of the signed contract or a completed Network Participation Form, available from the [Provider Forms web page](#) under the Provider Enrollment and Update Forms drop-down, must be scanned and attached on the "Attachments and Fees" panel.


Using the drop-down, providers may select from available Colorado networks. The networks available for selection at this time are:

<input type="checkbox"/> ASOD - DentaQuest USA Insurance	<input type="checkbox"/> PACE - InnovAge/Total Longterm Care Lakewood
<input type="checkbox"/> CHP+ - Colorado Access	<input type="checkbox"/> PACE - InnovAge/Total Longterm Care Loveland
<input type="checkbox"/> CHP+ - DentaQuest USA	<input type="checkbox"/> PACE - InnovAge/Total Longterm Care Thornton
<input type="checkbox"/> CHP+ - Denver Health Medical Plan Inc.	<input type="checkbox"/> PACE - Rocky Mountain Health Care Services
<input type="checkbox"/> CHP+ - Kaiser Permanente	<input type="checkbox"/> PACE - Senior Community Care
<input type="checkbox"/> CHP+ - Rocky Mountain HMO Inc.	<input type="checkbox"/> RAE (Region 1) Rocky Mountain Health Plans
<input type="checkbox"/> MCO - Denver Health Medical Choice	<input type="checkbox"/> RAE (Region 2) Northeast Health Partners
<input type="checkbox"/> MCO - Rocky Mountain Health Plans Prime	<input type="checkbox"/> RAE (Region 3) Colorado Access
<input type="checkbox"/> MCO - Total Longterm Care Pueblo (PACE)	<input type="checkbox"/> RAE (Region 4) Health Colorado, Inc.
<input type="checkbox"/> MCO - TRU Community Care (PACE)	<input type="checkbox"/> RAE (Region 5) Colorado Access
<input type="checkbox"/> PACE - HopeWest	<input type="checkbox"/> RAE (Region 6) Colorado Community Health Alliance
<input type="checkbox"/> PACE - InnovAge/Total Longterm Care Aurora	<input type="checkbox"/> RAE (Region 7) Colorado Community Health Alliance
<input type="checkbox"/> PACE - InnovAge/Total Longterm Care Denver	<input type="checkbox"/> Colorado Access Behavioral Health for Denver Health Medicaid Choice (DHMC)

Once a network and its effective date have been chosen, click the Add button to add it to the list.

***Network Participation Panel – MCO/RAE Add Network***

Managed Care Network	Effective Date	Action
<input type="checkbox"/> Click to collapse.		
*Network <input type="text" value="MCO - Rocky Mountain"/>	*Effective Date <input type="text" value="03/08/2017"/>	
<input type="button" value="Add"/>		
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>		




If a provider is a member of more than one network, click the "+" to add another network. Repeat the same steps as above to do this until this panel of the application is complete.

***Network Participation Panel – MCO/BHO Network Add another MCO Network***

Required fields and click the "Add" button. Click "Remove" to remove the entire form.

Managed Care Network	Effective Date	Action
<input type="checkbox"/> MCO - Rocky Mountain Health Plans Prime	03/08/2017	<a href="#">Remove</a>
<input type="checkbox"/> Click to add Managed Care Network		
<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>		



When the panel is complete, select "Continue", "Finish Later", or "Cancel".



## Languages Panel

Provider Enrollment: Languages ?													
<a href="#">Welcome</a>	<p>Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the <b>"Add"</b> button. Click <b>"Remove"</b> to remove the entire row.</p> <table border="1"> <thead> <tr> <th>Language</th> <th>Proficiency</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="3"><input type="checkbox"/> Click to collapse.</td> </tr> <tr> <td>*Language <input type="text"/></td> <td>Proficiency <input type="text"/></td> <td></td> </tr> <tr> <td colspan="3"><input type="button" value="Add"/></td> </tr> </tbody> </table>	Language	Proficiency	Action	<input type="checkbox"/> Click to collapse.			*Language <input type="text"/>	Proficiency <input type="text"/>		<input type="button" value="Add"/>		
Language		Proficiency	Action										
<input type="checkbox"/> Click to collapse.													
*Language <input type="text"/>		Proficiency <input type="text"/>											
<input type="button" value="Add"/>													
<a href="#">Request Information</a>													
<a href="#">Change of Ownership</a>													
<a href="#">Specialties</a>													
<a href="#">Addresses</a>													
<a href="#">Provider Identification</a>													
<a href="#">Network Participation</a>													
<b>▶ Languages</b>	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>												
EFT Enrollment													
Other Information													
Addendums													
Disclosures													
Attachments and Fees													
Agreement													
Summary													

On this panel, the user may enter any languages and the proficiency level spoken within the office or facility. The user may add as many as needed. This information will be shown in the Colorado Medicaid Provider Look-up. There are currently 60 languages available to choose from.

After each language is selected, click the **"Add"** button. The screen will update and add the selected item to the list of languages. If a language needs to be removed, click the **"Remove"** link on the right of the screen. Add as many languages as needed to reflect the enrolling provider's capabilities.

### *Languages Panel – Add additional Language*

Provider Enrollment: Languages <span style="float: right;">?</span>											
<a href="#">Welcome</a> <a href="#">Request Information</a> <a href="#">Change of Ownership</a> <a href="#">Specialties</a> <a href="#">Addresses</a> <a href="#">Provider Identification</a> <a href="#">Network Participation</a> <b>▶ Languages</b> EFT Enrollment Other Information Addendums Disclosures Attachments and Fees Agreement Summary	<p>Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required.</p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the <b>"Add"</b> button. Click <b>"Remove"</b> to remove the entire row.</p> <table border="1"> <thead> <tr> <th>Language</th> <th>Proficiency</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>English</td> <td>Native/Bilingual Proficiency</td> <td><a href="#">Remove</a></td> </tr> <tr> <td colspan="3"> <input type="button" value="+"/> Click to add language.               </td> </tr> </tbody> </table> <div style="text-align: right; margin-top: 10px;"> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </div>		Language	Proficiency	Action	English	Native/Bilingual Proficiency	<a href="#">Remove</a>	<input type="button" value="+"/> Click to add language.		
Language	Proficiency	Action									
English	Native/Bilingual Proficiency	<a href="#">Remove</a>									
<input type="button" value="+"/> Click to add language.											

When the panel is complete, select **"Continue"**, **"Finish Later"**, or **"Cancel"**.

## Electronic Funds Transfer (EFT) Enrollment Panel

**NOTE:** The Electronic Funds Transfer (EFT) panel will not display for PACE-Only Subcontractor provider enrollment types.

The following comprehensive list describes the fields on the EFT Enrollment panel:

### EFT Enrollment Panel – Part 1

**Provider Enrollment: EFT Information**

Welcome

**EFT Enrollment**

Attachments

Agreement

Summary

In order to have payments electronically deposited, Providers must enter all applicable fields within the Financial Institution Information section below. Financial Institution Address is optional and can be added by clicking the checkbox next to Financial Institution Address. For further explanation on EFT Enrollment, please refer to the Help page by clicking the question mark near the top of the screen.

\* Indicates a required field.

**Provider Information**

\*Provider Name

Business Name

Provider Address is an optional. If you wish to include provider address information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

☒ **Provider 'Pay To' Address**

\*Address

\*City

\*State  \*Zip Code/Postal Code

\*Country

**Provider Identification Numbers**

\*Tax ID

\*NPI must be provided if one has been issued.

Provider National Provider Identifier (NPI)

Other Identifier  Assigning Authority

Trading Partner ID

Provider License Number  License Issuer

Provider Type

Taxonomy

**Provider Contact Information**

\*Provider Contact Name  Suffix

\*Phone  Ext

\*Email  Fax Number

A scanned copy of a bank letter or a voided business check needs to be added on the “Attachments and Fees” panel.

This panel collects information needed for direct deposit of claims reimbursement into a bank account via Electronic Funds Transfer (EFT). EFT allows quicker access to claim payments by depositing them directly to the bank account.

Not all enrollment types will see this panel. If the user is an Individual within a Group, the user will not see this panel as the Group submits claims on behalf of the individual and would be responsible for submitting the information for this panel. If the user is an OPR provider, the user will not see this panel as an OPR provider does not submit claims for payment.

### Provider Information Section

**Provider Name** – Complete legal name of institution, corporate entity, practice, or individual provider. If applicable, this field is display only and supplied by the value from the Provider Identification panel. This field is prepopulated with the value entered previously in the application.

**Business Name** – The name under which the business or operation is conducted. If applicable, this field is display only and supplied by the value from the Provider Identification panel. This field is prepopulated with the value entered previously in the application.

### Provider Pay To Address Section

**Address** – Enter the address associated to the provider. If applicable, this field is display only and supplied by the value from the 'Pay To' address panel.

**City** – Enter the city associated to the provider address. If applicable, this field is display only and supplied by the value from the 'Pay To' Address page. This field allows up to 30 alphanumeric characters.

**State** – State associated to the provider's 'Pay To' address.

**Zip Code / Postal Code** – Zip Code associated to the provider address. If applicable, this field is display only and supplied by the value from the 'Pay To' Address page.

**Country** – Country code associated to the provider's address. This field is supplied by the values from the 'Pay To' Addresses page.

### Provider Identification Numbers Section

**Tax ID** – A Federal Tax Identification Number used to identify the business entity. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows nine numeric characters.

**Provider National Provider Identifier (NPI) (Provider Identification Numbers)** – Unique identification number for the provider. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten numeric characters.

**Other Identifier** – Additional provider identifier. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten alphanumeric characters.

**Assigning Authority** – Organization that issues and assigns the additional provider identifier. If applicable, this field is display only and supplied by the value from the Request Information page. Use the drop-down to make a selection. Assigning Authority is a required field if Other Identifier is entered.

**Trading Partner ID** – Provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor. This field allows ten alphanumeric characters and is optional.

**Provider License Number** – Provider's License Number. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows 20-alphanumeric characters.

**License Issuer** – Entity that issued the provider's license number. This field allows up to 30 alphanumeric characters. License Issuer is supplied by the Request Information page.

**Provider Type** – Type of provider. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows 50 alphanumeric characters.

**Taxonomy Code** – Provider's Taxonomy Code. The code set is structured into three distinct levels including provider type, classification and area of specialization. If applicable, this field is display only

and supplied by the value from the Request Information page. This field allows ten alphanumeric characters.

### **Provider Contact Information Section**

**Provider Contact Name** – Name of the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows up to 70 alphanumeric characters.

**Suffix (Provider Contact)** – Suffix of the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows up to 30 alphanumeric characters.

**Phone (Provider Contact)** – Phone number for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten numeric characters.

**Ext (Provider Contact)** – Telephone Number Extension for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows four numeric characters.

**Email (Provider Contact)** – Email Address for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows 50 alphanumeric characters. Enter a valid email address with 'name@domain' format.

**Fax Number (Provider Contact)** – Fax Number for the contact person. If applicable, this field is display only and supplied by the value from the Request Information page. This field allows ten numeric characters. Enter a fax number in the format '999-999-9999'.

This panel also includes several optional sections that can be completed during the Enrollment process. These sections are indicated by blue arrows on the panel below.

*EFT Enrollment Panel – Part 2*

☐ **Provider Agent Information**

Federal Agency Information is optional. If you wish to provide federal agency information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

☐ **Federal Agency Information**

Retail Pharmacy Information is optional. If you wish to include retail pharmacy information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

☐ **Retail Pharmacy Information**

**Financial Institution Information**

Financial Institution Address is optional. If you wish to include financial institution address with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

☐ **Financial Institution Address**

\*Financial Institution Name

Financial Institution Telephone Number  Ext

\*ABA Routing Number

\*Type of Account at Financial Institution

\*Provider's Account Number with Financial Institution

**Account Number Linkage to Provider Identifier**

Enter either a Provider Tax Identification Number (TIN) or Provider National Provider Identifier (NPI) for grouping (bulking) claim payments - must match preference for v5010 X12 835 remittance advice reference

Provider Tax Identification Number (TIN)

Provider National Provider Identifier (NPI)

**Submission Information**

Reason For Submission New Enrollment

Include with Enrollment Submission

Requested EFT Start/Change/Cancel Date 08/04/2015

Clicking on the white checkboxes will open each optional area. This information is not required but can be entered if desired. Unchecking the box will close this section and remove any information entered in these fields.

## Provider Agent Information Section

☒ **Provider Agent Information**

Agent Address is optional. If you wish to include agent address with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

☒ **Agent Address**

**\*Address**

**\*City**

**\*State**

**Country**

**\*Zip Code/Postal Code**

**\*Provider Agent Name**

**\*Provider Agent Contact Name**  **Suffix**

**\*Phone**  **Ext**

**\*Email**  **Fax Number**

Federal Agency Information is optional. If you wish to provide federal agency information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

**Agent Address** – Enter the number and street name of the agent address. This field allows up to 55 alphanumeric characters. Enter the number and street name of the agent address. This field is only required when the Agent Address check box has been checked.

**City** – Enter the city associated to the agent address. Enter as 30 Alphanumeric characters. This field is only required when the Agent Address check box has been checked.

**State** – State associated to the agent address. Use the drop-down to make a selection. This field is only required when the Agent Address check box has been checked.

**Zip Code / Postal Code** – Zip Code associated to the agent address. This field allows nine numeric characters. This field is only required when the Agent Address check box has been checked.

**Country** – Country codes associated to the agent address. Use the drop-down to make a selection. This field is only required when the Agent Address check box has been checked.

**Provider Agent Name** – Name of the agent. This field allows up to 70 alphanumeric characters. This field is only required when the Provider Agent Information check box has been checked.

**Provider Agent Contact Name** – Enter the name of the agent contact. This field allows up to 70 alphanumeric characters. This field is only required when the Provider Agent Information check box has been checked.

**Suffix (Agent Contact)** – Suffix of the agent contact. This field allows up to 30 alphanumeric characters. This field is only required when the Agent Address check box has been checked.

**Phone (Agent Contact)** – Phone number for the agent contact. This field allows ten numeric characters. Enter a phone number in the format '999-999-9999'. This field is only required when the Provider Agent Information check box has been checked.

**Ext (Agent Contact)** – Telephone Number Extension for the agent contact. This field allows four numeric characters. This field is only required when the Agent Address check box has been checked.

**Email (Agent Contact)** – Email Address for the agent contact. This field allows up to 50 alphanumeric characters. Enter a valid email address with 'name@domain' format. This field is only required when the Provider Agent Information check box has been checked.

**Fax Number (Agent Contact)** – Fax Number for the agent contact. Enter as 10-Numeric characters. Enter a fax number in the format '999-999-9999'. This field is required.

### Federal Agency Information Section

<input checked="" type="checkbox"/> Federal Agency Information	
<b>Federal Program Agency Name</b>	<input type="text"/>
<b>Federal Program Agency Identifier</b>	<input type="text"/>
<b>Federal Agency Location Code</b>	<input type="text"/>

Retail Pharmacy Information is optional. If you wish to include retail pharmacy information with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

**Federal Program Agency Name** – Name of the Federal Program Agency. This field allows up to 70 alphanumeric characters.

**Federal Program Agency Identifier** – Identifier of the Federal Program Agency. This field allows up to ten alphanumeric characters.

**Federal Agency Location Code** – Location Code of the Federal Program Agency. This field allows up to 25 alphanumeric characters.



**Retail Pharmacy Information Section**

<input checked="" type="checkbox"/> Retail Pharmacy Information	
*Pharmacy Name	<input type="text"/>
Chain Number	<input type="text"/>
Parent Organization ID	<input type="text"/>
Payment Center ID	<input type="text"/>
NCPDP Provider ID Number	<input type="text"/>
Medicaid Provider Number	<input type="text"/>

**Pharmacy Name** – Enter the Pharmacy Name. This field allows up to 70 alphanumeric characters. This field is only required when the Retail Pharmacy Information check box has been checked.

**Chain Number** – Enter the identification number assigned to the entity allowing linkage for a business relationship, i.e. chain, buying groups or third-party contracting organizations. This may also be known as Affiliation ID or Relation ID. This field allows five alphanumeric characters.

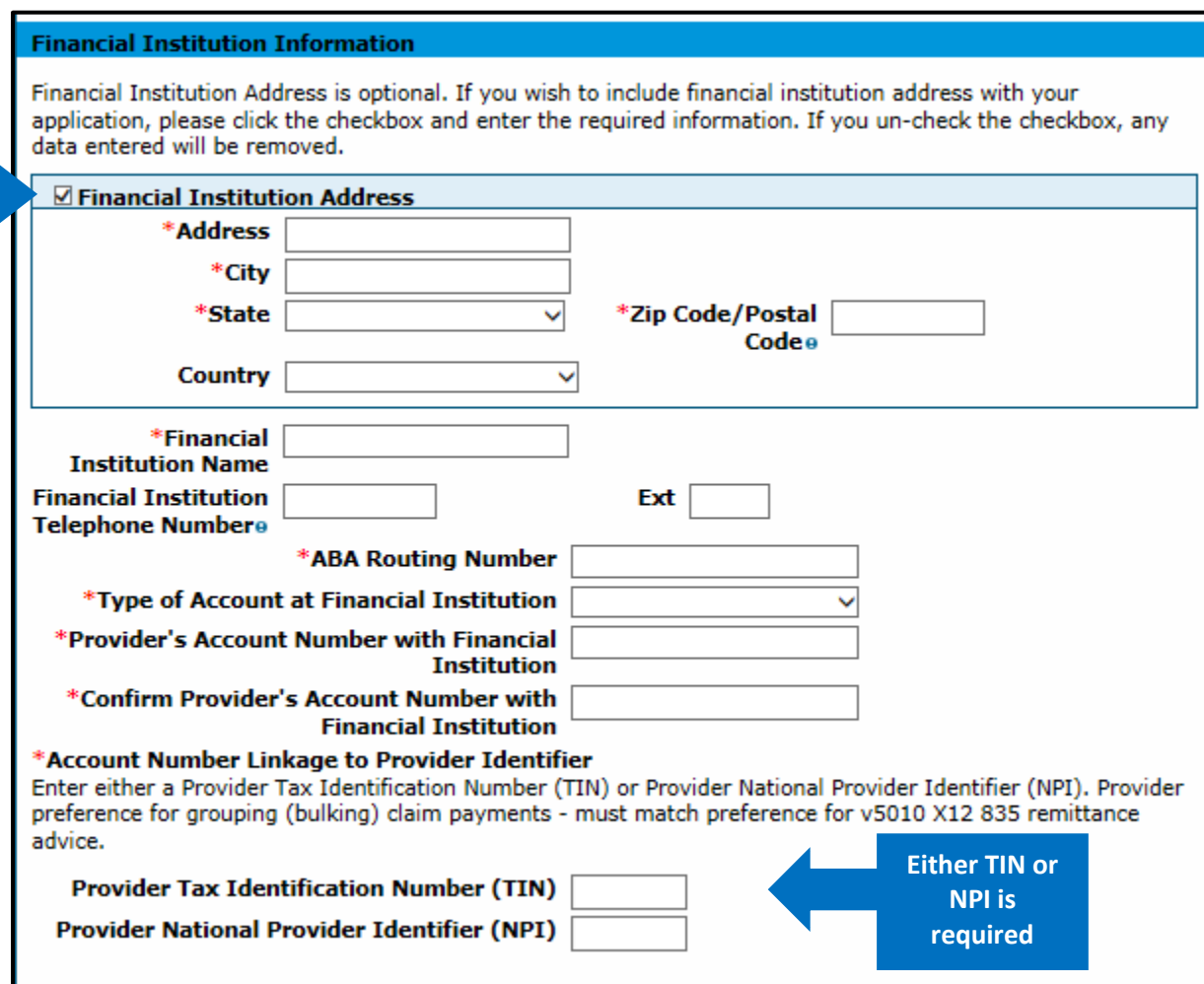
**Parent Organization ID** – Headquarter information for chains, buying groups or third-party contracting organizations where multiple relationship entities exist and need to be linked to a common organization such as common ownership for several chains. This field allows ten alphanumeric characters.

**Payment Center ID** – The assigned payment center identifier associated with the provider/corporate entity. This field allows ten alphanumeric characters.

**NCPDP Provider ID Number** – The National Council for Prescription Drug Programs (NCPDP) assigned unique identification number. This field allows seven alphanumeric characters.

**Medicaid Provider Number** – A number issued to a provider by the U.S. Department of Health and Human Services through state health and human services agencies. This field allows ten alphanumeric characters.

## Financial Institution Information Section



**Financial Institution Information**

Financial Institution Address is optional. If you wish to include financial institution address with your application, please click the checkbox and enter the required information. If you un-check the checkbox, any data entered will be removed.

☒ **Financial Institution Address**

\*Address

\*City

\*State  \*Zip Code/Postal Code

Country

\*Financial Institution Name

Financial Institution Telephone Number  Ext

\*ABA Routing Number

\*Type of Account at Financial Institution

\*Provider's Account Number with Financial Institution

\*Confirm Provider's Account Number with Financial Institution

\*Account Number Linkage to Provider Identifier  
Enter either a Provider Tax Identification Number (TIN) or Provider National Provider Identifier (NPI). Provider preference for grouping (bulking) claim payments - must match preference for v5010 X12 835 remittance advice.

Provider Tax Identification Number (TIN)

Provider National Provider Identifier (NPI)

Either TIN or NPI is required

Within the Financial Institution section of the Enrollment page, there are several fields that are indicated with a red asterisk. These are required fields that must be completed. Additionally, the user has the option to enter the Financial Institution's address information. This can be done by clicking the white checkbox indicated by a blue arrow on the panel above.

**Address (Financial Institution)** – Enter the number and street name of the financial institution address. This field allows up to 55 alphanumeric characters. This field is only required when the Financial Institution Address check box has been checked.

**City (Financial Institution)** – Enter the city associated to the financial institution address. This field allows up to 30 alphanumeric characters. This field is only required when the Financial Institution Address check box has been checked.

**State (Financial Institution)** – State associated to the financial institution address. Use the drop-down to make a selection. This field is only required when the Financial Institution Address check box has been checked.

**Zip Code / Postal Code (Financial Institution)** – Zip Code associated to the financial institution address. This field allows nine numeric characters. This field is only required when the Financial Institution Address check box has been checked.

**Country (Financial Institution)** – Country codes associated to the financial institution address. Use the drop-down to make a selection. This field is only required when the Financial Institution Address check box has been checked.

**Financial Institution Name** – Name of the provider's financial institution. This field allows up to 39 alphanumeric characters. This field is required.

**Financial Institution Telephone Number** – Phone number for the provider's financial institution. This field allows ten numeric characters. Enter a phone number in the format '999-999-9999'. This field is only required when the Financial Institution Address check box has been checked.

**Ext (Financial Institution)** – Telephone Number Extension for the provider's financial institution. This field allows four numeric characters. This field is only required when the Financial Institution Address check box has been checked.

**ABA Routing Number** – Enter as the 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited. This field allows nine numeric characters. This field is required.

**Type of Account at Financial Institution** – The type of account the provider will use to receive EFT payments, e.g. Checking, Savings. Use the drop-down to make a selection. Type of Account at Financial Institution is a required field.

**Provider's Account Number with Financial Institution** – Provider's account number at the financial institution to which EFT payments are to be deposited. This field allows ten alphanumeric characters. This field is required.

**Provider Tax Identification Number (TIN)** – (Financial Institution Information) – Federal Tax Identification Number used to identify a business entity. This field allows nine numeric characters. Either a provider's NPI or TIN is required.

**Provider National Provider Identifier (NPI) (Financial Institution Information)** – Unique identification number for the provider. This field allows ten numeric characters. Either a provider's NPI or TIN is required.

### Submission Information Section

**Submission Information**

Reason For Submission New Enrollment

Include with Enrollment Submission on the Attachments and Fees page

Requested EFT Start/Change/Cancel Date

Continue Finish Later Cancel

**Reason For Submission** – Reason for the EFT enrollment. “New Enrollment” is the only option and is what will populate here.

**Include with Enrollment Submission** – The bank account verification document type needs to be attached as part of the enrollment application. Use the drop-down to make a selection between “Bank Letter” or “Voided Check”. The user will need to attach the bank letter or the voided check in the “Attachment and Fees” panel.

**Requested EFT Start/Change/Cancel Date** – Date on which the requested action is submitted. As part of the enrollment application this field is display only and defaulted to the current date. This field allows eight numeric (MM/DD/YYYY) characters.

When the panel is complete, select “**Continue**”, “**Finish Later**”, or “**Cancel**”.

## Other Information Panel

**NOTE:** The Other Information panel will not display for PACE-Only Subcontractor provider enrollment types.

The example below displays a Group enrollment type. The screen may look similar to the following:

**Provider Enrollment: Other Information**

Welcome

Additional information is provided for each enrollment, for group/facility and individual providers.

\* Indicates a required field.

**Malpractice/General Liability Insurance**

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

All Applicants must complete. Malpractice/General liability insurance is mandatory under current State and Federal law.

Name	Policy ID	Effective Date	Expiration Date	Action
Click to collapse.				
*Carrier Name	*Policy ID	*Effective Date	*Expiration Date	
*Insurance Type				
*Effective Date				
<input type="button" value="Add"/> <input type="button" value="Reset"/>				

**Supplemental Questions**

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE

Medicaid Participation

**Medicaid Participation**

- \*Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?  
☐ Yes ☐ No
- \*Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)?  
☐ Yes ☐ No
- \*Have you ever been denied enrollment for cause in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)?  
☐ Yes ☐ No
- \*Has your enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated or revoked for cause?  
☐ Yes ☐ No
- \*Have you ever been excluded from participation in Medicare, Medicaid and all other Federal health care programs by the Office of the Inspector General, U.S. Department of Health and Human Services?  
☐ Yes ☐ No
- \*Have you ever been excluded from participation in federal procurement?  
☐ Yes ☐ No
- \*Do you hold all licenses and certifications as required based on your provider type?  
☐ Yes ☐ No
- \*Is this license expired, or subject to conditions or restrictions?  
☐ Yes ☐ No
- \*Have you ever been subject to a payment suspension based on a credible allegation of fraud?  
☐ Yes ☐ No
- \*Do you currently have an outstanding overpayment of \$1,500 or more that is over 30 days past due, you have not entered into a payment plan for, and is not currently the subject of an appeal?  
☐ Yes ☐ No

**Additional Information**

Please begin the Provider Website with "http:///" or "https://".

Website Address

The Other Information panel is where the user may enter any other additional information as applicable to the practice or facility. The Provider Enrollment tool will automatically present the appropriate questions based on the Enrollment Type chosen earlier in the process. This can include degrees, schools attended, number of Medicaid-eligible or certified/licensed beds, and liability insurance information.

An example of each Other Information panel is listed in the sections directly following this section. Below is a comprehensive list of all the Other Information fields that could be present:

### Malpractice / General Liability Insurance Section


**Carrier Name** – Enter the name of the insurance carrier. This field allows up to 25 alphanumeric characters. This field is required.

**Policy ID** – Enter the Policy ID for the insurance carrier. This field allows up to 20 alphanumeric characters. This field is required.

**Effective Date** – Enter the Effective Date for the provider insurance. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.

**Expiration Date** - Enter the Expiration Date for the provider insurance. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.



Select the  button to add the policy. If additional policies need to be entered, click '+' to add policies:

All Applicants must complete, Malpractice/General liability insurance is mandatory under current State and Federal law.				
Name	Policy ID	Effective Date	Expiration Date	Action
<input type="checkbox"/> Nationwide	456987123	02/08/2019	02/08/2020	<a href="#">Remove</a>
<input type="checkbox"/> Click to add commercial insurance.				

**Supplemental Questions Section**

Select Yes or No for the Supplemental Questions. This field is required.

**Supplemental Questions**

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE  
Medicaid Participation

**Medicaid Participation**

- \*Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**  
☐ Yes ☐ No
- \*Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**  
☐ Yes ☐ No
- \*Have you ever been denied enrollment for cause in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)?**  
☐ Yes ☐ No
- \*Has your enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated or revoked for cause?**  
☐ Yes ☐ No
- \*Have you ever been excluded from participation in Medicare, Medicaid and all other Federal health care programs by the Office of the Inspector General, U.S. Department of Health and Human Services?**  
☐ Yes ☐ No
- \*Have you ever been excluded from participation in federal procurement?**  
☐ Yes ☐ No
- \*Do you hold all licenses and certifications as required based on your provider type?**  
☐ Yes ☐ No
- \*Is this license expired, or subject to conditions or restrictions?**  
☐ Yes ☐ No
- \*Have you ever been subject to a payment suspension based on a credible allegation of fraud?**  
☐ Yes ☐ No
- \*Do you currently have an outstanding overpayment of \$1,500 or more that is over 30 days past due, you have not entered into a payment plan for, and is not currently the subject of an appeal?**  
☐ Yes ☐ No

Answering 'Yes' to questions 1-4 will open a required text box to elaborate on the answer.

**Supplemental Questions**

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE  
Medicaid Participation

**Medicaid Participation**

1. **\*Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**  
☒ Yes ☐ No  
**\*Which states?**

2. **\*Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**  
☒ Yes ☐ No  
**\*Which states?**

3. **\*Have you ever been denied enrollment for cause in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)?**  
☒ Yes ☐ No  
**\*Which states?**

4. **\*Has your enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated or revoked for cause?**  
☒ Yes ☐ No  
**\*Which states?**

5. **\*Have you ever been excluded from participation in Medicare, Medicaid and all other Federal health care programs by the Office of the Inspector General, U.S. Department of Health and Human Services?**  
☐ Yes ☐ No

6. **\*Have you ever been excluded from participation in federal procurement?**  
☐ Yes ☐ No

7. **\*Do you hold all licenses and certifications as required based on your provider type?**  
☐ Yes ☐ No

8. **\*Is this license expired, or subject to conditions or restrictions?**  
☐ Yes ☐ No

9. **\*Have you ever been subject to a payment suspension based on a credible allegation of fraud?**  
☐ Yes ☐ No

10. **\*Do you currently have an outstanding overpayment of \$1,500 or more that is over 30 days past due, you have not entered into a payment plan for, and is not currently the subject of an appeal?**  
☐ Yes ☐ No



**Additional Information Section**

**Web Site Address** – Enter the Provider's web site URL. This field allows up to 55 alphanumeric characters. This field is not required.

**Institutional Bed Information Section**

**A facility enrollment type will have the following section in these panels:**

***Assisted Care Facilities***

Institutional Bed Information			
Nursing Facility applicants must complete.			
<b>Number Skilled Beds</b>	<input type="text" value="100"/>	<b>Effective Date</b>	<input type="text" value="02/02/2021"/> <input type="button" value="⌵"/>
<b>End Date</b>	<input type="text" value="12/31/2299"/> <input type="button" value="⌵"/>	<b>Number ICF Beds</b>	<input type="text" value="25"/>
<b>Effective Date</b>	<input type="text" value="01/01/2015"/> <input type="button" value="⌵"/>	<b>End Date</b>	<input type="text" value="12/31/2299"/> <input type="button" value="⌵"/>

**Number of ICF Beds** – Enter the number of beds at the nursing facility for Intermediate Care Facilities (ICF) patients. This field allows five numeric characters. This field is required.

**Effective Date** – Enter the Effective date of the hospital bed. Enter eight characters in MM/DD/YYYY format. This field is required.

**End Date** – Enter the End date of the hospital bed. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.

***Hospitals***

Institutional Bed Information		
Hospital applicants must complete. Number of Inpatient Beds, Effective Date and End Date are required if any Institutional Bed Information is entered. If no end date enter the max end date of 12/31/2299.		
<b>Number of Inpatient Beds</b>	<input type="text" value="220"/>	<b>Effective Date</b>
<b>End Date</b>	<input type="text" value="01/01/2021"/> <input type="button" value="⌵"/>	<input type="text" value="12/31/2299"/> <input type="button" value="⌵"/>

**Number of Skilled Beds** – Enter the Number of beds in a facility that are certified and/or licensed. This field allows five numeric characters. This field is required.

**Effective Date** – Enter the Effective date of the hospital bed. Enter eight characters in MM/DD/YYYY format. This field is required.

**End Date** – Enter the End date of the hospital bed. This field allows eight numeric characters in MM/DD/YYYY format. This field is required.

***SUD Disorder Facilities***

**Substance Use Disorder Bed Information**

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

**Substance Use Disorder applicants must complete.** Number of SUD Beds, Effective Date, and End Date are all required.

**Note:** The number of beds must be the total number of beds at this service location address regardless of:

- the number allocated to individual levels of care;
- the number of beds allotted for detox versus treatment or;
- the number allotted for psychiatric versus substance use disorder treatment.

Outpatient programs should enter zero "0" in the "Number of SUD Beds" field.

When entering the Effective Date:

- enter today's date or;
- if submitting a change in the number of beds, enter the date when the change in bed count was effective.

When entering the End Date, a future date must be entered (e.g. 12/31/2299) to avoid the need to update the system if no changes to bed counts occur.

	Number of SUD Beds	Effective Date	End Date	Action
+	16	01/01/2020	12/31/2020	
+	0	01/01/2018	12/31/2018	
+	12	01/01/2019	12/31/2019	
- Click to collapse.				

**\*Number of SUD Beds**

**\*Effective Date**

**\*End Date**

For more information on updating bed counts for (Assisted Care Facilities, Hospitals, and Substance Use Disorder Facilities), visit the [Provider Maintenance Provider Web Portal Quick Guide web page](#).

An individual enrollment with a provider type 24 Non-physician Practitioner Individual (Registered Nurses only) will have the following section on this panel:

On Premise Supervision for non-physician practitioners (Registered Nurses Only)
<p><b>Registered nurses, by state regulation, require on premise supervision and must complete this form to enroll with Colorado Medicaid.</b></p> <p><b>Registered Nurses (Other than employees of a Certified Health Department* and employees of a Nurse Home Visitor Program (NHVP) site**).</b></p> <p><b>Benefit services by registered nurses must be provided in compliance with the following requirements:</b></p> <ul style="list-style-type: none"> <li>Services must be performed under the direct and personal supervision of an advanced practice nurse (APN) or physician (MD) who is immediately available when services are provided. This means that the supervising APN/MD must be physically present on the premises when the service is provided.           <ul style="list-style-type: none"> <li>The on premise requirement does not apply to targeted case management provided by registered nurses under the Nurse Home Visitor Program. Registered nurses can provide this service without a supervising APN/MD on premises.</li> </ul> </li> <li>Services must be ordered by the supervising APN/MD.</li> <li>Claims must be submitted through the supervising APN/MD. Registered nurses must look to the supervising or billing APN/MD for compensation.</li> <li>The supervising APN/MD Colorado Medical Assistance Program provider number must appear on the claim form as the supervising physician, the referring provider, or the billing provider.</li> <li>Claims must be billed using procedure codes specifically designated for non-physician billing.</li> <li>Claims must identify the registered nurse with provider number, as the rendering provider.</li> <li>The registered nurse applicant must identify the Colorado Medical Assistance Program enrolled APN/MD(s) who will provide supervision.</li> </ul> <p><b>Add each supervisor's name and NPI in the APN/MD table below. Each supervisor's original signature must be included as an attachment with this enrollment. Click <a href="#">here</a> to download the supervisor signature form. An original signature assures that the supervisor is aware of and understands the supervisory role and requirements.</b></p> <p>* Employees of a Certified Health Agency (CHA) do not require on premise supervision. Check the "Certified Health Agency" box below and enter the agency's provider name and National Provider Identifier (NPI) in the APN/MD table below. A separate attachment including an original signature is not required for the CHA.</p> <p>** Employees of a Nurse Home Visitor Program (NHVP) site providing case management services do not require on premise supervision. Check the "Nurse Home Visitor Program" box below to attest that enrollment is for the NHVP and enter the name of the Nurse Home Visitor program site. A separate attachment including an original signature is not required for the NHVP.</p> <p><b>Certified Health Agency</b> <input type="checkbox"/></p> <p><b>Nurse Home Visitor Program</b> <input type="checkbox"/> <b>Program Name</b> <input type="text"/></p> <p>Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.</p>

Supervising APN/MD			
Last Name	First Name	NPI	Action
<input type="checkbox"/> Click to collapse.			
<b>Last Name</b> <input type="text"/> <b>NPI</b> <input type="text"/>	<b>First Name</b> <input type="text"/>		
<input type="button" value="Add"/> <input type="button" value="Reset"/>			

Registered Nurses are required to complete and attach the [RN Supervision Form](#), found on the [Provider Forms web page](#) under the Provider Enrollment & Update Forms drop-down, in addition to completing information on the 'On Premise Supervision for non-physician practitioners' panel in the application.

### **On Premise Supervision for non-physician practitioners (registered nurses only) Section**

**Nursing Home Visitor Program question** – This checkbox is used to indicate if the registered nurse is exempt from entering information for the on-premise supervision. Nurses participating only in the Nursing Home Visitor Program are not required to enter a supervising APN/MD. They are required to enter the program site name if the box is checked. This field is required.

**Nursing Home Visitor Program Name**– Enter the name of the nursing home visitor program the registered nurse is participating in. This field allows up to 50 alphanumeric characters. This field is required.

### **Supervising APN/MD Section**

**Last Name** – Enter the last name of the supervising APN/MD. This field allows up to 60 Alphanumeric characters. This field is required.

**First Name** – Enter the first name of the supervising APN/MD. This field allows up to 50 alphanumeric characters. This field is required.

**NPI** – Enter the NPI assigned to the supervising APN/MD. This field allows 15 Alphanumeric characters. This field is required.

## Addendums Panel

**NOTE:** The Addendums panel will not display for PACE-Only Subcontractor provider enrollment types.

This is an example of an Addendums panel. **Only when enrolling as a pharmacy will there be anything to complete here. Select the link to complete the Dispensing Fee Attestation Questionnaire.**

**Provider Enrollment: Addendums**


[Welcome](#)  
[Request Information](#)  
[Change of Ownership](#)  
[Specialties](#)  
[Addresses](#)  
[Provider Identification](#)  
[Network Participation](#)  
[Languages](#)  
[EFT Enrollment](#)  
[Other Information](#)  
**Addendums**

These addendum(s) are required to gather information about your operation, which is needed for enrollment/revalidation.

**Available Enrollment Addendums**

Click the addendum name to open the addendum for editing. After completing the addendum, select **Submit** to return to this page.  
All Addendums must be completed to **Continue**.

Addendum	Description	Status
<a href="#">PHARMACY DISPENSING FEE ADDENDUM</a>	<b>Dispensing Fee Attestation Questionnaire</b> The Colorado Department of Health Care Policy and Financing (the Department) reimburses outpatient pharmacies for both the costs related to acquiring a drug and the costs related to dispensing the drug to a Medicaid member.	New



[Continue](#)[Finish Later](#)[Cancel](#)

## Answer Enrollment Addendum Questions Section (Pharmacy Only)

Answer Enrollment Addendum Questions															
<h3>Dispensing Fee Attestation Questionnaire</h3> <p>The Colorado Department of Health Care Policy and Financing (the Department) reimburses outpatient pharmacies for both the costs related to acquiring a drug and the costs related to dispensing the drug to a Medicaid member. The dispensing fees for retail, 340B, and mail order pharmacies are based upon the pharmacy's total annual prescription volume. The dispensing fees for rural and government pharmacies are based on the pharmacy type.</p> <p>The dispensing fees and their requirements are as follows:</p> <table border="1"> <thead> <tr> <th>Requirements</th> <th>Dispensing Fee</th> </tr> </thead> <tbody> <tr> <td>0 - 59,999 TAPV:</td> <td>\$13.40</td> </tr> <tr> <td>60,000 - 89,999 TAPV:</td> <td>\$11.49</td> </tr> <tr> <td>90,000 - 109,999 TAPV:</td> <td>\$10.25</td> </tr> <tr> <td>110,000 + TAPV:</td> <td>\$ 9.31</td> </tr> <tr> <td>Rural Pharmacy:</td> <td>\$14.14</td> </tr> <tr> <td>Government Pharmacy:</td> <td>\$ 0.00</td> </tr> </tbody> </table> <p>TAPV = Total Annual Prescription Volume</p> <p>This questionnaire is intended to establish a dispensing fee for any new pharmacy enrolling as a Medicaid provider. A new pharmacy must complete this questionnaire stating their total prescription volume for the previous twelve (12) months. If a new pharmacy has been open for less than one year, the pharmacy should include the total prescription volume for the months the pharmacy has been open.</p> <p><b>All fields must be completed.</b></p> <p>If you have any questions concerning this questionnaire, please email <a href="mailto:Colorado.SMAC@state.co.us">Colorado.SMAC@state.co.us</a> or you may call the Department's Pharmacy Liaison at 303-866-3588.</p>		Requirements	Dispensing Fee	0 - 59,999 TAPV:	\$13.40	60,000 - 89,999 TAPV:	\$11.49	90,000 - 109,999 TAPV:	\$10.25	110,000 + TAPV:	\$ 9.31	Rural Pharmacy:	\$14.14	Government Pharmacy:	\$ 0.00
Requirements	Dispensing Fee														
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110,000 + TAPV:	\$ 9.31														
Rural Pharmacy:	\$14.14														
Government Pharmacy:	\$ 0.00														
<h3>PHARMACY DISPENSING FEE ADDENDUM</h3> <p>Total # of Questions: 8</p>															
<h4>Total Annual Prescription Volume</h4> <p>Please list the total number of prescriptions dispensed in the last 12 months. If the pharmacy has been open for less than 12 months, please list the total number of prescriptions dispensed for the months the pharmacy has been open. If the pharmacy is the only Medicaid-participating pharmacy within twenty miles (driving distance) of its physical location, then claim "Yes" on the rural line. NOTE: The prescription date range should not exceed one (1) year.</p> <p>1. *Total Prescriptions:  <input type="text"/></p> <p>2. *From Date: <input type="text"/></p> <p>3. *To Date: <input type="text"/></p>															
<p>4. *Rural:  <input type="radio"/> Yes <input type="radio"/> No</p> <h4>Prescription Volume Breakdown</h4> <p>Please list the approximate percentage of prescriptions dispensed for each classification NOTE: The percentages should add up to 100%.</p> <p>5. *Medicaid %:  <input type="text"/></p> <p>6. *Medicare %:  <input type="text"/></p> <p>7. *Other 3rd Party %:  <input type="text"/></p> <p>8. *Cash %:  <input type="text"/></p> <p style="text-align: right;"><a href="#">Submit</a> <a href="#">Cancel</a></p>															
R05.00.295	<a href="#">Privacy Notice</a>														

## Disclosures Panel

**NOTE:** The Disclosures panel will not display for PACE-Only Subcontractor provider enrollment types.

Disclosures are required for every enrollment and involve information regarding ownership/control interest, relationships, criminal convictions, etc. Select each Disclosure link and answer all questions contained within the disclosure.

The Disclosures indicate a “New” status on the right-hand side of the panel until each is complete. All Disclosures must be completed to proceed with the enrollment.



Provider Enrollment: Disclosures ?																						
<a href="#">Welcome</a>	<p><b>Privacy Act Notice Statement</b></p> <p>This statement explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs) and dates of birth (DOB), may be requested and used. Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the Colorado Medical Assistance Program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation. Any information may also be provided to the U.S. DHHS Centers for Medicare and Medicaid Services, the Internal Revenue Service, the Colorado Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state or local agencies as appropriate. Providing this information is mandatory to be eligible to enroll as a provider with the Colorado Medical Assistance Program, pursuant to 42 C.F.R. § 433.37. Failure to submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Colorado Medical Assistance Program.</p> <p><b>Ownership/Controlling Interest and Conviction Disclosure</b></p> <p>Disclosure of information regarding ownership and control and on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services programs is required by the Centers for Medicare and Medicaid Services and the Colorado Department of Health Care Policy and Financing pursuant to regulations found at 42 CFR § 455.100 through 42 CFR § 455.106. The following disclosures must be made to Colorado Medicaid utilizing the Disclosure links in the table below.</p> <ul style="list-style-type: none"> <li><b>All entities, fiscal agents and managed care entities</b> (<a href="#">see definitions</a>) must disclose the information required in <b>Disclosure A through F</b>.</li> <li><b>Answer all questions</b> by selecting the Yes/No buttons and entering the required information in the text area. The Disclosure is incomplete if a text field is left blank, or if an entry is partially completed.</li> </ul>																					
<a href="#">Request Information</a>																						
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<a href="#">Specialties</a>																						
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<b>Disclosures</b>																						
Attachments and Fees																						
Agreement																						
Summary																						
<p><b>Available Enrollment Disclosures</b></p> <p>Click the disclosure name to open the disclosure for editing. After completing the disclosure, select <b>"Add"</b>. When you have completed the disclosure, click <b>"Submit"</b> to return to the main Disclosures page. All Disclosures must be completed to <b>Continue</b>.</p> <table border="1"> <thead> <tr> <th>Disclosure Name</th> <th>Description</th> <th>Status</th> </tr> </thead> <tbody> <tr> <td><a href="#">A. OWNERSHIP OR CONTROL INTEREST</a></td> <td>Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more, an officer/director of a corporation or a partner of a partnership.</td> <td>Completed</td> </tr> <tr> <td><a href="#">B. SUBCONTRACTOR OWNERSHIP</a></td> <td>Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.</td> <td>Completed</td> </tr> <tr> <td><a href="#">C. INDIVIDUAL RELATIONSHIPS</a></td> <td>Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.</td> <td>Completed</td> </tr> <tr> <td><a href="#">D. MANAGING EMPLOYEES</a></td> <td>Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.</td> <td>Completed</td> </tr> <tr> <td><a href="#">E. BUSINESS RELATIONSHIPS</a></td> <td>Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.</td> <td>Completed</td> </tr> <tr> <td><a href="#">F. CONVICTIONS OF CRIMINAL OFFENSE</a></td> <td>Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.</td> <td>Completed</td> </tr> </tbody> </table> <p><a href="#">Continue</a> <a href="#">Finish Later</a> <a href="#">Cancel</a></p>		Disclosure Name	Description	Status	<a href="#">A. OWNERSHIP OR CONTROL INTEREST</a>	Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more, an officer/director of a corporation or a partner of a partnership.	Completed	<a href="#">B. SUBCONTRACTOR OWNERSHIP</a>	Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.	Completed	<a href="#">C. INDIVIDUAL RELATIONSHIPS</a>	Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.	Completed	<a href="#">D. MANAGING EMPLOYEES</a>	Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.	Completed	<a href="#">E. BUSINESS RELATIONSHIPS</a>	Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.	Completed	<a href="#">F. CONVICTIONS OF CRIMINAL OFFENSE</a>	Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.	Completed
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**Disclosure A** is regarding ownership and controlling interest for the applicant. Indicate the information for each person (individual or corporation) with an ownership or controlling interest for the applicant. For individual applicants (SSN enrollments) it is recommended to select the 'No' option in the first question to indicate that ownership/control interest does not apply to the individual.

### ***Disclosures Panel – Ownership/Controlling Interest Disclosure A***

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

#	Disclosure Name	Action
<input type="checkbox"/>	Click to collapse.	
<div style="background-color: #0070C0; color: white; padding: 5px; text-align: center;"> <b>Disclosure A Information - Ownership/Controlling Interest</b> </div> <p><b>Enter the percent interest, name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity. Corporations, LLC, Non-Profits must list Officers and Directors. Government agencies must list board members if organized as a corporation. Additionally, corporate entities must attach a separate list of primary business address, every business location, and P.O. Box address. (Individuals enrolling/enrolled with an SSN, select "No" to question 1 to indicate there is no ownership/control interest applicable.)</b></p> <p>1. <b>*Is there any person (individual or corporation) with an ownership or control interest in the disclosing entity as indicated above?</b>  <input type="radio"/> Yes <input type="radio"/> No</p> <p>2. <b>*Is the entity entered above an individual?</b>  <input type="radio"/> Yes <input type="radio"/> No</p> <p style="text-align: center;"><a href="#" style="border: 1px solid #0070C0; padding: 2px 5px; color: #0070C0; text-decoration: none;">Add</a></p>		

A "Yes" answer will open an additional section as shown below, for the required information to be entered.

**Disclosure A Information - Ownership/Controlling Interest**

Enter the percent interest, name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity. Corporations, LLC, Non-Profits must list Officers and Directors. Government agencies must list board members if organized as a corporation. Additionally, corporate entities must attach a separate list of primary business address, every business location, and P.O. Box address. (Individuals enrolling/enrolled with an SSN, select "No" to question 1 to indicate there is no ownership/control interest applicable.)

1. **\*Is there any person (individual or corporation) with an ownership or control interest in the disclosing entity as indicated above?**

☒ Yes ☐ No

**\*% Interest:**

15

**Organization Name: (OR)**

**First Name:**

First

**Middle Initial:**

**Last Name:**

Last

**\*Street Address:**

123 No Street

**\*City:**

Denver

**\*State:**

CO

**\*Zip:**

800140000

**\*SSN/EIN:**

123456789

2. **\*Is the entity entered above an individual?**

☒ Yes ☐ No

**\*Date of Birth:**

01/01/1950

**Add**

If the entity is an individual owner, then they must select 'Yes' to question 2 and enter the individual's date of birth, as shown above. If the user selects that the entity is not an individual, but enters information for an individual, the application will be returned to the user to correct the information.

When this information is complete, click the "Add" button and the panel will update as shown below.

***Disclosures Panel – Ownership/Controlling Interest Disclosure A – Add or Submit***

**Answer Enrollment Disclosure Questions**
?

**Ownership/Controlling Interest and Conviction Disclosure**


Disclosure of information regarding ownership and control and on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services programs is required by the Centers for Medicare and Medicaid Services and the Colorado Department of Health Care Policy and Financing pursuant to regulations found at 42 CFR § 455.100 through 42 CFR § 455.106. The following disclosures must be made to Colorado Medicaid.


- **All entities, fiscal agents and managed care entities** [\(see definitions\)](#) must disclose the information required in **Disclosures A through F**.
- **Answer all questions** by selecting the Yes/No buttons and entering the required information in the text area. The Disclosure is incomplete if a text field is left blank, or if an entry is partially completed.

\* Indicates a required field.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

#	Disclosure Name	Action
+	A. OWNERSHIP OR CONTROL INTEREST	<a href="#">Remove</a>
+	Click to add new Provider Disclosure	





**Submit**
**Cancel**

Continue to add entities as applicable. For additional entries click on the "+" symbol on the left-hand side of the panel.

When all Ownership/Controlling Interest is entered, click on the **"Submit"** button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed", as shown below.

***Disclosures Panel – Ownership/Controlling Interest Disclosure A – Completed*****Available Enrollment Disclosures**

Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

Disclosure Name	Description	Status
<a href="#">A. OWNERSHIP OR CONTROL INTEREST</a>	Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more, an officer/director of a corporation or a partner of a partnership.	Completed
<a href="#">B. SUBCONTRACTOR OWNERSHIP</a>	Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.	New
<a href="#">C. INDIVIDUAL RELATIONSHIPS</a>	Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.	New
<a href="#">D. MANAGING EMPLOYEES</a>	Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.	New
<a href="#">E. BUSINESS RELATIONSHIPS</a>	Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.	New
<a href="#">F. CONVICTIONS OF CRIMINAL OFFENSE</a>	Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.	New



**Disclosure B** is regarding Subcontractor Ownership and Control. Indicate all persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity/applicant has direct or indirect ownership of 5% or more.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “**Add**” button and the panel will update.

### *Disclosures Panel – Subcontractor Ownership and Control Disclosure B - Questions*

Click “+” to view or update the details in a row. Click “-” to collapse the row. To add a new row, enter all the required fields and click the “**Add**” button. Click “**Remove**” to remove the entire row.

#	Disclosure Name	Action
<input type="checkbox"/>	Click to collapse.	
<div style="background-color: #0070C0; color: white; padding: 5px; text-align: center;"><b>Disclosure B Information - Subcontractor Ownership and Control</b></div> <p><b>Enter the percent interest, name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person or entity with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. If "None", select "No" to indicate that subcontractor ownership/control interest does not apply.</b></p> <p>1. <b>*Is there any person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership as indicated above?</b>  <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p><b>*% Interest:</b>  <input type="text"/></p> <p><b>*Full Name: (If this is an individual-enter First, Middle, Last.)</b>  <input type="text"/></p> <p><b>*Street Address:</b>  <input type="text"/></p> <p><b>*City:</b>  <input type="text"/></p> <p><b>*State:</b>  <input type="text"/></p> <p><b>*Zip:</b>  <input type="text"/></p> <p><b>*SSN/EIN:</b>  <input type="text"/></p> <p>2. <b>*Is the entity entered above an individual?</b>  <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p><b>*Date of Birth:</b>  <input type="text"/> <input type="button" value="📅"/></p> <p style="text-align: center;"><input type="button" value="Add"/></p>		

Continue to add entities as applicable. When all Subcontractor Ownership and Control information is entered, click on the “**Submit**” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

**Disclosure C** is regarding Individual Relationships. Indicate any individuals mentioned in Disclosure A and Disclosure B that are related to one another as a spouse, parent, child or sibling.

A “Yes” answer will open an additional section for the required information to be entered.

### *Disclosures Panel – Individual Relationships Disclosure C – Questions*

Click “+” to view or update the details in a row. Click “-” to collapse the row. To add a new row, enter all the required fields and click the “Add” button. Click “Remove” to remove the entire row.

#	Disclosure Name	Action
[-]	C. INDIVIDUAL RELATIONSHIPS	<a href="#">Remove</a>

**Disclosure C Information - Individual Relationships**

**List the name, social security number, date of birth, and relationship for any of the persons mentioned in Disclosures A and B, or persons mentioned in any other disclosing entity who are related to one another as a spouse, parent, child or sibling.**

1. **\* Are there any persons mentioned in Disclosure A and B related to one another, or to any other person (individual or corporation) with an ownership or control interest in any other provider enrolled in the Colorado Medical Assistance Program?**  
☒ Yes ☐ No

**\* Full Name of Person 1:**

**\* SSN:**

**\* Date of Birth:**

**\* Relationship:**

**\* Full Name of Person 2:**

**\* SSN:**

Click to add new Provider Disclosure

When the information is completed, click the “Add” button and the panel will update.

Continue to add individuals as applicable. When all Individual Relationships are entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

**Disclosure D** is regarding Managing Individuals. Indicate any individuals that hold a position of managing employee within the disclosing entity/applicant.

A “**Yes**” answer will open an additional section for the required information to be entered. When the information is completed, click the “**Add**” button and the panel will update.

***Disclosures Panel – Managing Individuals Disclosure D – Questions***

**Disclosure D Information - Managing Individuals**

List any person who holds a position of managing employee within the disclosing entity, fiscal agent or managed care entity. If no person meets the criteria, select "No".

1. **\*Is there any person who holds a position of managing employee as outlined above?**  
☒ Yes ☐ No

**\*First Name:**

**Middle Initial:**

**Last Name:**

**\*SSN:**

**\*Date of Birth:**

**\*Street Address:**

**\*City:**

**\*State:**

**\*Zip:**

Continue to add individuals as applicable. When all Managing Individuals are entered, click on the “**Submit**” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

**Disclosure E** is regarding Business Relationships. Indicate any persons or entity (identified in Disclosure A) that has an ownership or controlling interest of 5% or greater in any other provider, fiscal agent or managed care entity.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “Add” button and the panel will update.

### *Disclosures Panel – Business Relationships Disclosure E– Questions*

Click “+” to view or update the details in a row. Click “-” to collapse the row. To add a new row, enter all the required fields and click the “Add” button. Click “Remove” to remove the entire row.

#	Disclosure Name	Action
<input type="checkbox"/>	Click to collapse.	
<div> <div>Disclosure E Information - Business Relationships</div> <div> <p>List any person or entity (identified in Disclosure A) that has an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity. If no person or entity meets the criteria above, select “No”.</p> <p>1. <b>*Is there any individual with an ownership or control interest as outlined above?</b>  <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>% Interest: <input type="text"/></p> <p><b>*Full Name of Provider:</b> <input type="text"/></p> <p>SSN: <input type="text"/></p> <p>Date of Birth: <input type="text"/></p> <p><b>*Full Name Other Provider:</b> <input type="text"/></p> <p>SSN/EIN: <input type="text"/></p> <p>2. <b>*Is there any business, organization or corporation with an ownership or control interest as outlined above?</b>  <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>% Interest: <input type="text"/></p> <p><b>*Full Name of Provider:</b> <input type="text"/></p> <p>EIN: <input type="text"/></p> <p><b>*Full Name Other Provider:</b> <input type="text"/></p> <p>SSN/EIN: <input type="text"/></p> <p><input type="button" value="Add"/></p> </div> </div>		




Continue to add entities as applicable. When all Business Relationships are entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.



**Disclosure F** is regarding Convictions. Indicate any persons with ownership or controlling interest in, or that is an agent or managing employee of the applicant who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.

### *Disclosures Panel – Conviction Disclosure F – Questions*

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

#	Disclosure Name	Action
	Click to collapse.	
<div style="background-color: #0070C0; color: white; padding: 5px; text-align: center;"> <b>Disclosure F Information - Conviction Disclosure</b> </div> <p>List any person (individual or corporation) who has an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of:</p> <ul style="list-style-type: none"> <li>▪ a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHP+ or the Title XX services since the inception of these programs;</li> <li>▪ neglect or abuse of a patient, in connection with the delivery of a health care item or service;</li> <li>▪ fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than Medicare and a State health care program) operated by, or financed in whole or in part, by any Federal, State or local government agency;</li> <li>▪ an offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.</li> </ul> <p>1. <b>*Is there any person who has been convicted of a criminal offense as outlined above?</b>  <input checked="" type="radio"/> Yes <input type="radio"/> No  <b>*Full Name:</b>  <input type="text"/>  <b>*SSN/EIN:</b>  <input type="text"/>  <b>*Offense:</b>  <input type="text"/>  <b>*Conviction Date:</b>   <input type="text"/>  <b>*Jurisdiction:</b>  <input type="text"/></p> <p>2. <b>*Is the entity entered above an individual?</b>  <input checked="" type="radio"/> Yes <input type="radio"/> No  <b>*Date of Birth:</b>   <input type="text"/></p> <p style="text-align: center;"><a href="#" style="background-color: #0070C0; color: white; padding: 5px 10px; text-decoration: none;">Add</a></p>		

A "Yes" answer will open an additional section for the required information to be entered. When the information is completed, click the **"Add"** button and the panel will update.

Continue to add entities as applicable. When all Convictions are entered, click on the **"Submit"** button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed".

When all questions have been completed within the Disclosures panel, select “Continue”, “Finish Later”, or “Cancel”.

### *Disclosures Panel – Completed*

Available Enrollment Disclosures		
Click the disclosure name to open the disclosure for editing. After completing the disclosure, select "Add". When you have completed the disclosure, click "Submit" to return to the main Disclosures page. All Disclosures must be completed to <b>Continue</b> .		
Disclosure Name	Description	Status
<a href="#">A. OWNERSHIP OR CONTROL INTEREST</a>	Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more, an officer/director of a corporation or a partner of a partnership.	Completed
<a href="#">B. SUBCONTRACTOR OWNERSHIP</a>	Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.	Completed
<a href="#">C. INDIVIDUAL RELATIONSHIPS</a>	Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.	Completed
<a href="#">D. MANAGING EMPLOYEES</a>	Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.	Completed
<a href="#">E. BUSINESS RELATIONSHIPS</a>	Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.	Completed
<a href="#">F. CONVICTIONS OF CRIMINAL OFFENSE</a>	Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.	Completed
<div> <a href="#">Continue</a> <a href="#">Finish Later</a> <a href="#">Cancel</a> </div>		

## Fingerprinting

**NOTE:** The Fingerprinting panel will not display for PACE-Only Subcontractor provider enrollment types.

If the enrolling provider is determined to be a **high-risk provider type**, as determined by CMS or the Department, they will be presented with, and required to complete, the **Fingerprinting panel**. This Provider's data is pulled from the Provider Identification panel and the Request Information panel in the application. Owner information will be populated by the individual owner information that is entered on the Disclosures panel in the application. For providers that are business entities, all owners with 5% or more interest in the business will be displayed with a status indicating any individuals that need to submit fingerprints at this time. The user may view the risk level by visiting the [Information by Provider Type web page](#).

### *Fingerprinting Panel – Fingerprinting and Criminal Background Check*

**Provider Enrollment: Fingerprinting and Criminal Background Check**

▪ All high-risk Providers and any Owner with 5% or more interest in the Provider, must complete a Fingerprint Criminal Background Check as part of enhanced enrollment screening provisions contained in Section 6401 of Affordable Care Act (ACA).

Please click [+] for EACH person identified below, and complete the answers before submitting.

	Type	Name	Tax ID	Status	Pass/Fail
<input type="checkbox"/>	Provider	ABC Company	252995536	Not Noticed	Not Completed
<input type="checkbox"/>	Owner	John Doe	738987654	Not Noticed	Not Completed

[Continue](#) [Finish Later](#) [Cancel](#)

Click on the “+” next to any Owner(s) that needs to complete fingerprinting. Then answer the questions presented within the panel.

***Fingerprinting Panel – Fingerprinting and Criminal Background Check – Marked No***

**Colorado**  
Department of Health Care  
Policy & Financing

**Health First COLORADO**  
Colorado's Medicaid Program  
[Contact Us](#) | [Login](#)

Home > [Provider Enrollment](#) > Fingerprinting Friday 08/23/2019 12:24 PM MST

**Provider Enrollment: Fingerprinting and Criminal Background Check**

[Welcome](#)  
[Request Information](#)  
[Change of Ownership](#)  
[Specialties](#)  
[Addresses](#)  
[Provider Identification](#)  
[Network Participation](#)  
[Languages](#)  
[EFT Enrollment](#)  
[Other Information](#)  
[Addendums](#)  
[Disclosures](#)  
**Fingerprinting**  
Attachments and Fees  
Agreement  
Summary

■ All high-risk Providers and any Owner with 5% or more interest in the Provider, must complete a Fingerprint Criminal Background Check as part of enhanced enrollment screening provisions contained in Section 6401 of Affordable Care Act (ACA).

Please click [+] for EACH person identified below, and complete the answers before submitting.

	Type	Name	Tax ID	Status	Pass/Fail
<input type="checkbox"/>	Provider	ABC Company	252995536	Not Noticed	Not Completed
This is a business entity and does not require fingerprinting for all individual owners listed					
<input type="checkbox"/>	Owner	John Doe	738987654	Not Noticed	Not Completed

\*Have you completed Fingerprinting for MEDICARE? ☐ Yes ☒ No  
 \*Have you completed Fingerprinting for MEDICAID in any State? ☐ Yes ☒ No

Fingerprints for all persons listed above must be submitted to the department within 30 days of the date of Application or Revalidation of a high-risk provider. Failure to respond within 30 days of submission of the application could result in the denial of the application. Individuals may NOT fingerprint themselves; fingerprints MUST be obtained from a State of Colorado approved CABS service provider. Please visit the [Colorado Bureau of Investigation](#) web page for more information.

[Save](#) [Reset](#) [Cancel](#)

[Continue](#) [Finish Later](#) [Cancel](#)

If an Owner has **not** completed their Fingerprinting Background Check (**for either MEDICARE or MEDICAID**), please follow the instructions on this panel to have fingerprints submitted within **30 calendar days** of the submission of the enrollment application.

Please review the Fingerprinting FAQ on the [Provider FAQ Central web page](#) and select Fingerprinting from the drop-down.

If an Owner has completed the Fingerprinting Background Check (**for either MEDICARE or MEDICAID**), mark “Yes” next to the appropriate selection. If marked “Yes”, the panel will update and request confirmation of which state the fingerprinting was completed in. Then check the box next to the acknowledgement statement.

***Fingerprinting Panel – Fingerprinting and Criminal Background Check – Marked Yes***

Provider Enrollment: Fingerprinting and Criminal Background Check					
<a href="#">Welcome</a>	<ul style="list-style-type: none"> <li>All high-risk Providers and any Owner with 5% or more interest in the Provider, must complete a Fingerprint Criminal Background Check as part of enhanced enrollment screening provisions contained in Section 6401 of Affordable Care Act (ACA).</li> </ul>				
<a href="#">Request Information</a>	Please click [+] for EACH person identified below, and complete the answers before submitting.				
<a href="#">Change of Ownership</a>	<input type="checkbox"/>	Provider	ABC Company	252995536	Not Noticed
<a href="#">Specialties</a>	This is a business entity and does not require fingerprints, please complete Fingerprinting for all individual owners listed				
<a href="#">Addresses</a>	<input type="checkbox"/>	Owner	John Doe	738987654	Not Noticed
<a href="#">Provider Identification</a>	<p><b>*Have you completed Fingerprinting for MEDICARE?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p><b>*Have you completed Fingerprinting for MEDICAID in any State?</b> <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p><b>*What state, including CO, was fingerprinting completed in? (if fingerprinting is complete for multiple states, enter the most recent state)</b> <input type="text"/></p> <p><input type="checkbox"/> By submitting this information I recognize that the Department will validate fingerprinting results with the entity reported above. If sufficient documentation to support the information submitted cannot be provided to the Department, I acknowledge that I may still need to submit Fingerprints to the Department to be in compliance with the ACA. (Box must be checked to save this information for each person listed).</p>				
<a href="#">Network Participation</a>	<input type="button" value="Save"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/>				
<a href="#">Languages</a>					
<a href="#">EFT Enrollment</a>					
<a href="#">Other Information</a>					
<a href="#">Addendums</a>					
<a href="#">Disclosures</a>					
<b>Fingerprinting</b>					
Attachments and Fees					
Agreement					
Summary					
	<input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/>				

R05.00.296

[Privacy Notice](#)

Click **“Save”** once completed for **each Owner** and then click **“Continue”** to the next section.

**Once the application is submitted, Providers and owners requiring fingerprinting will be given specific instructions on how to proceed.**

## Attachments and Fees Panel

Any required attachments may be submitted electronically on this panel. Please note that attachments sent by mail, email, or fax cannot be accepted. These must be added to the attachments and fees panel of the application.

### Attachments Section

**Not all documents listed under Supporting Documentation may apply to the application being submitted.**

**The user will need to scan and attach:**

- Insurance face sheet for Nursing Facilities.
- License or certifications (if applicable)
- W-9 signed and dated within the past 6 months (if applicable)
- Voided check or bank letter dated within the past 6 months (if applicable)

- For each MCO or RAE contracted with, attach a copy of one of the following if network participation has been indicated in the enrollment application:
  - A completed Network Participation Verification Form; or
  - The contract panel(s) that identifies the contracting parties, the program name (e.g. Denver Health Medicaid Choice, Colorado Access, etc.) and the panel(s) with signatures of both parties, including the date; or
  - The entire contract with the MCO or RAE.
- Proof of Lawful Presence form (ONLY required for Billing Individuals or Atypical providers billing under their SSN)
- Supervising Physician Signature Form (ONLY required for Registered Nurses)
- Hardship waiver request letter and supporting documentation (if applying for a hardship waiver)
- Proof of payment (if application fee has already been paid to Medicare or in another state for this location)
- Please see [Information by Provider Type web page](#) for any additional documentation required for the provider type.

To access any applicable forms that may need to be printed, completed, signed and uploaded to the enrollment application, visit the [Provider Forms web page](#) and select the Provider Enrollment & Update Forms drop-down.

If the user is attaching a Gainwell Technologies form with the enrollment, please read the forms carefully. Some forms will require the user to include additional attachments. For example, lawful presence also requires a photo ID. Behavioral Therapist form requires licenses, certifications, diplomas, etc.

To submit a required attachment, first click on the appropriate link to open the document. Some documents can be completed electronically while others will require the user to print and scan a document. The user should work with internal IT support if they are unfamiliar with this process.

### **Application Fee Section**

The Enrollment tool will also calculate any required Enrollment Fees and guide the user through the payment process.

The Affordable Care Act (ACA) requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidation and change of ownership, as required, and is assessed in full for each service location enrolled in Colorado Medicaid. Visit the [Provider Enrollment web page](#) for the current amount.

The Application Fee questions as shown in the panel below will only be displayed if the Enrollment Type selected previously should have a fee.

If the service location has enrolled or revalidated with Medicare or another state's Medicaid program (in the last 5 years) and paid an application fee, no fee is required. A copy of the receipt indicating payment is **not** required for proof of payment to Medicare. Proof of payment to another state's Medicaid program may be uploaded on this panel in the attachments section with a selection type of "Other".

**Financial Hardship** – If the user is requesting a waiver for financial hardship, include a letter describing the financial hardship and why the hardship justifies an exception, as well as any additional supporting documentation that the user believes may aid the Department and CMS in the determination. If the user chooses to apply for an application fee waiver, the enrollment will be delayed while a determination is made. The letter and supporting documentation must be uploaded on this panel in the attachments section with a selection type of “Other”.

An example of the Attachments and Fees panel is shown below.

### *Attachments and Fees Panel – No Fee Required*

Provider Enrollment: Attachments And Fees																			
<a href="#">Welcome</a> <a href="#">Request Information</a> <a href="#">Specialties</a> <a href="#">Addresses</a> <a href="#">Provider Identification</a> <a href="#">Network Participation</a> <a href="#">Languages</a> <a href="#">EFT Enrollment</a> <a href="#">Other Information</a> <a href="#">Addendums</a> <a href="#">Disclosures</a> <b>▶ Attachments and Fees</b> <a href="#">Agreement</a> <a href="#">Summary</a>	<b>Supporting Documentation</b> Please submit electronic copies of all documentation required for the selected Provider Type and Specialty. A list of required documents can be found on this website: <a href="http://Colorado.gov/HCPF/Information-Provider-Type">Colorado.gov/HCPF/Information-Provider-Type</a> . If a hardship exemption is being requested in lieu of the application fee, please upload the letter and supporting documentation here as well.  <b>Submit as Attachment:</b> <a href="#">Completed W-9 Form</a> (if applicable) <b>Submit as Attachment:</b> <a href="#">Completed Proof of Lawful Presence</a> (if applicable) <b>Submit as Attachment:</b> <a href="#">Completed Supervising Physician Signature Form</a> (if applicable) <b>Submit as Attachment:</b> License (if applicable)  * Indicates a required field.																		
	<b>Attachments</b> To add an attachment, complete the required fields and click the <b>Add</b> button. Attachments cannot be saved for later. If you are not intending to submit the application at this time, it is suggested to wait to upload any attachments until you are ready to submit.  <b>Note:</b> if you choose to "Upload" attachments by "File Transfer", a maximum of 5 MBs of information can be uploaded. The allowable file types are: bmp, doc, docx, gif, jpg, jpeg, pdf, ppt, tif, tiff, txt, xls, xlsx, csv.  Click the <b>Remove</b> link to remove the entire row.																		
	<table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="5"> <input type="checkbox"/> Click to collapse.               </td> </tr> <tr> <td></td> <td> <b>*Transmission Method</b>  <input type="text" value="FT-File Transfer"/> </td> <td> <b>*Upload File</b>  <input type="button" value="Choose File"/> No file chosen               </td> <td> <b>*Attachment Type</b>  <input type="text"/> </td> <td> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </td> </tr> </tbody> </table>	#	Transmission Method	File	Attachment Type	Action	<input type="checkbox"/> Click to collapse.						<b>*Transmission Method</b> <input type="text" value="FT-File Transfer"/>	<b>*Upload File</b> <input type="button" value="Choose File"/> No file chosen	<b>*Attachment Type</b> <input type="text"/>	<input type="button" value="Add"/> <input type="button" value="Cancel"/>	<div style="border: 2px solid blue; padding: 10px; color: white; text-align: center;">             Make sure the user clicks "Add" to attach each document.           </div>		
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	<b>Application Fee</b> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>No Application Fee Required</b> </div> <div style="text-align: right;"> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </div>																		

If a fee is NOT required for the provider type, the application will say "No Application Fee Required"



**Attachments and Fees Panel – Fee Required**

Provider Enrollment: Attachments And Fees																																		
<a href="#">Welcome</a> <a href="#">Request Information</a> <a href="#">Change of Ownership</a> <a href="#">Specialties</a> <a href="#">Addresses</a> <a href="#">Provider Identification</a> <a href="#">Network Participation</a> <a href="#">Languages</a> <a href="#">EFT Enrollment</a> <a href="#">Other Information</a> <a href="#">Addendums</a> <a href="#">Disclosures</a> <b>▶ Attachments and Fees</b> <a href="#">Agreement</a> <a href="#">Summary</a>	<b>Supporting Documentation</b> <p>The following actions need to be taken to complete the individual enrollment process. If you need to submit attachments, please follow the instructions in the Attachments panel below.</p> <p><b>Read:</b> <a href="#">Reference Information For Services Identification</a></p> <p><b>Submit as Attachment:</b> <a href="#">Completed W-9 Form</a></p> <p><b>Submit as Attachment:</b> <a href="#">Completed Proof of Lawful Presence</a></p> <p><b>Submit as Attachment:</b> <a href="#">Completed Supervising Physician Signature Form</a></p> <p><b>Submit as Attachment:</b> License</p> <p>* Indicates a required field.</p>																																	
	<b>Attachments</b> <p>To add an attachment, complete the required fields and click the <b>Add</b> button.</p> <p><b>Note:</b> if you choose to "Upload" attachments by "File Transfer", a maximum of 5 MBs of information can be uploaded.  The allowable file types are: bmp, doc, docx, gif, jpg, jpeg, pdf, ppt, tif, tiff, txt, xls, xlsx, csv.</p> <p>Click the <b>Remove</b> link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="5"> <input type="checkbox"/> Click to collapse. </td> </tr> <tr> <td></td> <td>*Transmission Method</td> <td>FT-File Transfer</td> <td></td> <td></td> </tr> <tr> <td></td> <td>*Upload File</td> <td colspan="3"></td> </tr> <tr> <td></td> <td>*Attachment Type</td> <td colspan="3"></td> </tr> <tr> <td colspan="5"> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </td> </tr> </tbody> </table>				#	Transmission Method	File	Attachment Type	Action	<input type="checkbox"/> Click to collapse.						*Transmission Method	FT-File Transfer				*Upload File					*Attachment Type				<input type="button" value="Add"/> <input type="button" value="Cancel"/>				
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	<b>Application Fee</b> <p>The Affordable Care Act requires certain providers to remit an application fee. The Centers for Medicare &amp; Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidation and change of ownership, as required, and is assessed in full for each service location enrolled in CO Medicaid.</p> <p>Please answer all questions. If you answer "NO" to all of the following questions, you must pay an application fee. <b>If you answer "Yes" to any of the following questions, do not pay a fee, and click the Continue button instead.</b></p>																																	

If a fee IS required for the provider type, this panel shows



If the user answers “Yes” to any of these questions they do not need to pay the fee. Just press “Continue” instead

Application Fee Questions	
<b>Medicare Enrollment - if the service location has enrolled or revalidated with Medicare within the last 5 years, is approved and paid an application fee, no fee is required.</b>	
1. *Are you an approved Medicare provider at this service location? <input type="radio"/> Yes <input type="radio"/> No	
<b>Medicaid Enrollment - if the service location has enrolled or revalidated with another state's Medicaid or Children's Health Insurance Program within the last 5 years, is approved and paid an application fee, no fee is required. (Upload proof of payment in the Attachments section above.)</b>	
2. *Have you enrolled or revalidated in another State's Medicaid or Children's Health Insurance Program within the last 5 years? <input type="radio"/> Yes <input type="radio"/> No	
<b>Financial Hardship - when requesting an application fee waiver, include a letter describing the financial hardship and why the hardship justifies an exception. Include any additional documentation in support of the request to help the Centers for Medicare and Medicaid Services (CMS) with the decision to waive or deny. Application processing will be delayed while CMS reviews and decides. (Upload the letter and documentation in the Attachments section above.)</b>	
3. *Are you requesting a waiver of the application fee because of financial hardship? <input type="radio"/> Yes <input type="radio"/> No	
<b>Providers with Multiple Enrollments at the same Service Location Address - Providers shall only pay one application fee per service location address. (Upload proof of payment in the Attachments section above.)</b>	
4. *Has this service location address previously paid an application fee to Colorado Medicaid? <input type="radio"/> Yes <input type="radio"/> No	
Amount Due XXX.00 ▪	
▪ To make a payment, click the link below. <a href="#">Online Bill Pay</a>	
<div>Continue Finish Later Cancel</div>	






If it is determined that an application fee is due, click the “**Online Bill Pay**” link, and a payment form will open in a pop-up window:

### Online Bill Pay Pop Up

**Online Bill Pay** ?

**Welcome to the Online Bill Pay Process**  
Please complete each section of the online bill pay process to make a one-time payment for your Colorado Medicaid bill.

The following forms of payment are accepted:



**Account Information**

☐ Personal ☒ Business

**\*Business Name**

**Address**

**City**  **State**  **Zip Code**

**Phone Number**

**Payment Information**

**\*Payment Method**

**\*Card Number**

**\*Verification Code**

**\*Card Expiration Date**

**\*Billing Address Zip Code**

**Payment Amount** \$XXX.XX

A credit/debit card processing fee of 2.95% or e-check processing fee of \$2.50 will be added during payment authorization.

Enter email address below to receive a confirmation email.

**\*Email Address**

**\*Email Address Confirmation**

**Authorize Payment**

Please verify your payment above and make any necessary changes. When verification is complete, click the "Authorize Payment" button below to submit your payment.

Your payment will not be processed until you click the "Authorize Payment" button below. Only click once to avoid duplicate payments. Once your payment has processed, you will receive a confirmation number that you can print for your records. Click the "Cancel" button below to stop this payment process and exit. Do not use your browser Back button.

**Authorize Payment** **Cancel**


**Note:** A processing fee of 2.95% is charged for a debit/credit card payment, and a processing fee of \$2.50 is charged for an e-check.

## Agreement Panel



**NOTE:** The Agreement panel will not display for PACE-Only Subcontractor provider enrollment types.

Below is the Agreement panel. The terms of enrollment are stated here. Acceptance of these terms is required in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.


Click the link to the “**Provider Participation Agreement**” and read the agreement. If multiple Payers were selected, multiple Provider Participation Agreements will be displayed and will be required to be read and acknowledged to complete the panel.

Provider Enrollment: Agreement	
<a href="#">Welcome</a>	<b>Instructions</b>
<a href="#">Request Information</a>	The terms of enrollment are stated below. The provider must accept these terms to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.
<a href="#">Specialties</a>	Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
<a href="#">Addresses</a>	Once the application is submitted and confirmed, a tracking number will be assigned. Print a copy of the tracking number and application for your records.
<a href="#">Provider Identification</a>	
<a href="#">Network Participation</a>	
<a href="#">Languages</a>	<b>Terms of Agreement</b>
<a href="#">EFT Enrollment</a>	<b>Provider Name</b> Test Provider
<a href="#">Other Information</a>	<b>Address</b> Denver 123 Denver Colorado, 80123-1234
<a href="#">Addendums</a>	<b>Tax ID</b> 314291931
<a href="#">Disclosures</a>	<b>NPI</b>
<a href="#">Attachments and Fees</a>	<b>Contact Name</b> Test Provider
<a href="#">Agreement</a>	<b>Contact Email</b> provider@provider.com
<a href="#">Summary</a>	<b>No provider application, enrollment form, provider authorization form (if applicable), or Provider Participation Agreement (PPA) will be processed without completion of this page.</b>
	Read and print the PPA(s) for your records. The PPA applies to all programs and payers.
	Note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until all applicable PPAs have been read.
	<b>Read and Print:</b> <a href="#">Title XIX Payer Provider Participation Agreement</a> 
	<input type="checkbox"/> I accept the Title XIX Payer PPA
	<b>Note:</b> The provider must review the applicable PPAs prior to signing below.
	You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.
	<b>*I accept</b> <input type="checkbox"/> I understand that my electronic signature is equivalent to written signature.
	<b>*Your Signature</b> <input type="text"/>
	(Entering your name in the box to the right will constitute your electronic signature.)
	<b>Suffix</b> <input type="text"/>
	<b>Submission Date</b> 04/06/2023
	<a href="#">Review</a> <a href="#">Finish Later</a> <a href="#">Cancel</a>

Once complete, a checkmark will then appear next to it:

Provider Enrollment: Agreement	
<a href="#">Welcome</a>	<b>Instructions</b>
<a href="#">Request Information</a>	The terms of enrollment are stated below. The provider must accept these terms to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.
<a href="#">Specialties</a>	Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
<a href="#">Addresses</a>	Once the application is submitted and confirmed, a tracking number will be assigned. Print a copy of the tracking number and application for your records.
<a href="#">Provider Identification</a>	
<a href="#">Network Participation</a>	
<a href="#">Languages</a>	<b>Terms of Agreement</b>
<a href="#">EFT Enrollment</a>	<b>Provider Name</b> Test Provider
<a href="#">Other Information</a>	<b>Address</b> Denver 123 Denver Colorado, 80123-1234
<a href="#">Addendums</a>	<b>Tax ID</b> 314291931
<a href="#">Disclosures</a>	<b>NPI</b>
<a href="#">Attachments and Fees</a>	<b>Contact Name</b> Test Provider
<a href="#">Agreement</a>	<b>Contact Email</b> provider@provider.com
<a href="#">Summary</a>	<b>No provider application, enrollment form, provider authorization form (if applicable), or Provider Participation Agreement (PPA) will be processed without completion of this page.</b>
	Read and print the PPA(s) for your records. The PPA applies to all programs and payers.
	Note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until all applicable PPAs have been read.
	<b>Read and Print:</b> <a href="#">Title XIX Payer Provider Participation Agreement</a> 
	<input type="checkbox"/> I accept the Title XIX Payer PPA 
	<b>Note:</b> The provider must review the applicable PPAs prior to signing below.
	You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.
	<b>*I accept</b> <input type="checkbox"/> I understand that my electronic signature is equivalent to written signature.
	<b>*Your Signature</b> <input type="text"/>
	(Entering your name in the box to the right will constitute your electronic signature.)
	<b>Suffix</b> <input type="text"/>
	<b>Submission Date</b> 04/06/2023
	<a href="#">Review</a> <a href="#">Finish Later</a> <a href="#">Cancel</a>

If the user does not print the provider participation agreement at this time, they may view a copy of this agreement on the [Provider Forms web page](#).

Provider Enrollment: Agreement ?	
<a href="#">Welcome</a>	<b>Instructions</b>
<a href="#">Request Information</a>	The terms of enrollment are stated below. The provider must accept these terms to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.
<a href="#">Specialties</a>	Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
<a href="#">Addresses</a>	Once the application is submitted and confirmed, a tracking number will be assigned. Print a copy of the tracking number and application for your records.
<a href="#">Provider Identification</a>	
<a href="#">Network Participation</a>	
<a href="#">Languages</a>	<b>Terms of Agreement</b>
<a href="#">EFT Enrollment</a>	<b>Provider Name</b> Test Provider
<a href="#">Other Information</a>	<b>Address</b> Denver 123 Denver Colorado, 80123-1234
<a href="#">Addendums</a>	<b>Tax ID</b> 314291931
<a href="#">Disclosures</a>	<b>NPI</b>
<a href="#">Attachments and Fees</a>	<b>Contact Name</b> Test Provider
<a href="#">Agreement</a>	<b>Contact Email</b> provider@provider.com
<a href="#">Summary</a>	<b>No provider application, enrollment form, provider authorization form (if applicable), or Provider Participation Agreement (PPA) will be processed without completion of this page.</b>
	Read and print the PPA(s) for your records. The PPA applies to all programs and payers.
	Note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until all applicable PPAs have been read.
	<b>Read and Print:</b> <a href="#">Title XIX Payer Provider Participation Agreement</a> ▼
	<input checked="" type="checkbox"/> I accept the Title XIX Payer PPA 
	<b>Note:</b> The provider must review the applicable PPAs prior to signing below.
	You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.
	<b>*I accept</b> <input type="checkbox"/> I understand that my electronic signature is equivalent to written signature.
	<b>*Your Signature</b> <input type="text"/>
	(Entering your name in the box to the right will constitute your electronic signature.)
	<b>Suffix</b> <input type="text"/>
	<b>Submission Date</b> 04/06/2023
	<a href="#">Review</a> <a href="#">Finish Later</a> <a href="#">Cancel</a>

Click the "I accept" checkbox for each Provider Participation Agreement.

Enter the Provider name as the electronic signature and click in the "I accept" box in order to complete the panel. The "Review" button will then become active:

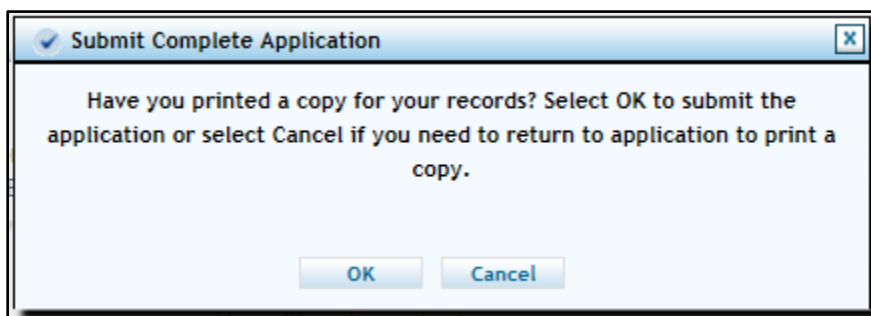
**Agreement Panel - Provider Participation Agreement**

Provider Enrollment: Agreement ?	
<a href="#">Welcome</a>	<b>Instructions</b>
<a href="#">Request Information</a>	The terms of enrollment are stated below. The provider must accept these terms to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.
<a href="#">Specialties</a>	Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
<a href="#">Addresses</a>	Once the application is submitted and confirmed, a tracking number will be assigned. Print a copy of the tracking number and application for your records.
<a href="#">Provider Identification</a>	
<a href="#">Network Participation</a>	
<a href="#">Languages</a>	<b>Terms of Agreement</b>
<a href="#">EFT Enrollment</a>	<b>Provider Name</b> Test Provider
<a href="#">Other Information</a>	<b>Address</b> Denver 123 Denver Colorado, 80123-1234
<a href="#">Addendums</a>	<b>Tax ID</b> 314291931
<a href="#">Disclosures</a>	<b>NPI</b>
<a href="#">Attachments and Fees</a>	<b>Contact Name</b> Test Provider
<a href="#">Agreement</a>	<b>Contact Email</b> provider@provider.com
<a href="#">Summary</a>	<b>No provider application, enrollment form, provider authorization form (if applicable), or Provider Participation Agreement (PPA) will be processed without completion of this page.</b>
	Read and print the PPA(s) for your records. The PPA applies to all programs and payers.
	Note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until all applicable PPAs have been read.
	<b>Read and Print:</b> <a href="#">Title XIX Payer Provider Participation Agreement</a> ▼
	<input checked="" type="checkbox"/> I accept the Title XIX Payer PPA
	<b>Note:</b> The provider must review the applicable PPAs prior to signing below.
	You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.
	<b>*I accept</b> <input checked="" type="checkbox"/> I understand that my electronic signature is equivalent to written signature.
	<b>*Your Signature</b> <input type="text" value="Test Provider"/>
	(Entering your name in the box to the right will constitute your electronic signature.)
	<b>Suffix</b> <input type="text"/>
	<b>Submission Date</b> 04/06/2023
	<a href="#">Review</a> <a href="#">Finish Later</a> <a href="#">Cancel</a>

## Summary Panel

This panel will show the application in its entirety. At this point, the user should review all information that has been entered for accuracy. The user may be requested to confirm the information and print a copy of the summary.

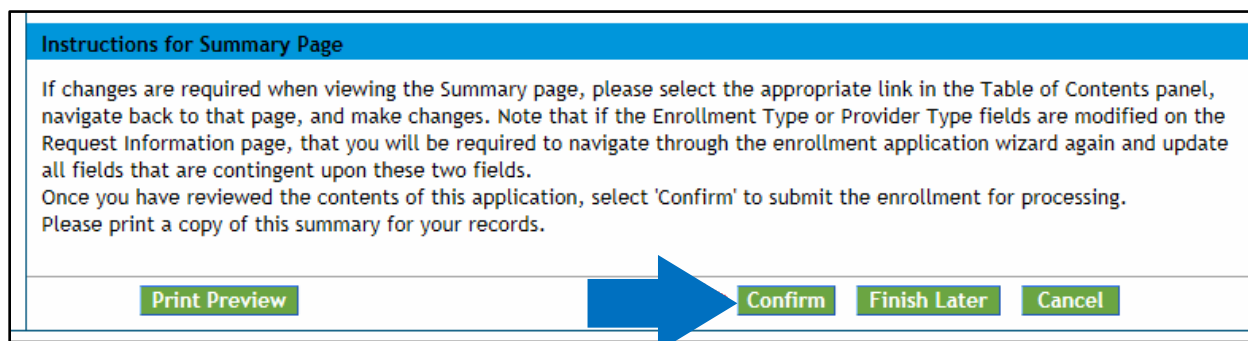
The user will be asked if they have printed a copy of this enrollment for your records. If the user has already printed a copy, or do not wish to print a copy, click **“OK”**. If the user would like to print a copy and has not done so yet, click **“Cancel”** to return to the application to print a copy.



Once the confirmation dialog box shown above disappears, click **“Confirm”** to submit the application for processing.

**The application is not submitted for processing until the Confirm button at the bottom of the summary page is clicked:**

### *Enrollment Summary Panel – Confirm Button – Application Submission*



If the user has not previously saved the application, they will be prompted to set up a password and security questions as reviewed in the 'Completing Application' section of the manual.



## After the application has been submitted

[Please visit the Next Steps web page for further instructions.](#)

### Resources

The Provider Manual is also supplemented with the [Provider FAQ Central web page](#). This list is updated often and should be bookmarked for future reference.

For additional support, providers may contact Gainwell Technologies, Fiscal Agent for Health First Colorado, by calling the [Provider Services Call Center](#) at 1-844-235-2387.

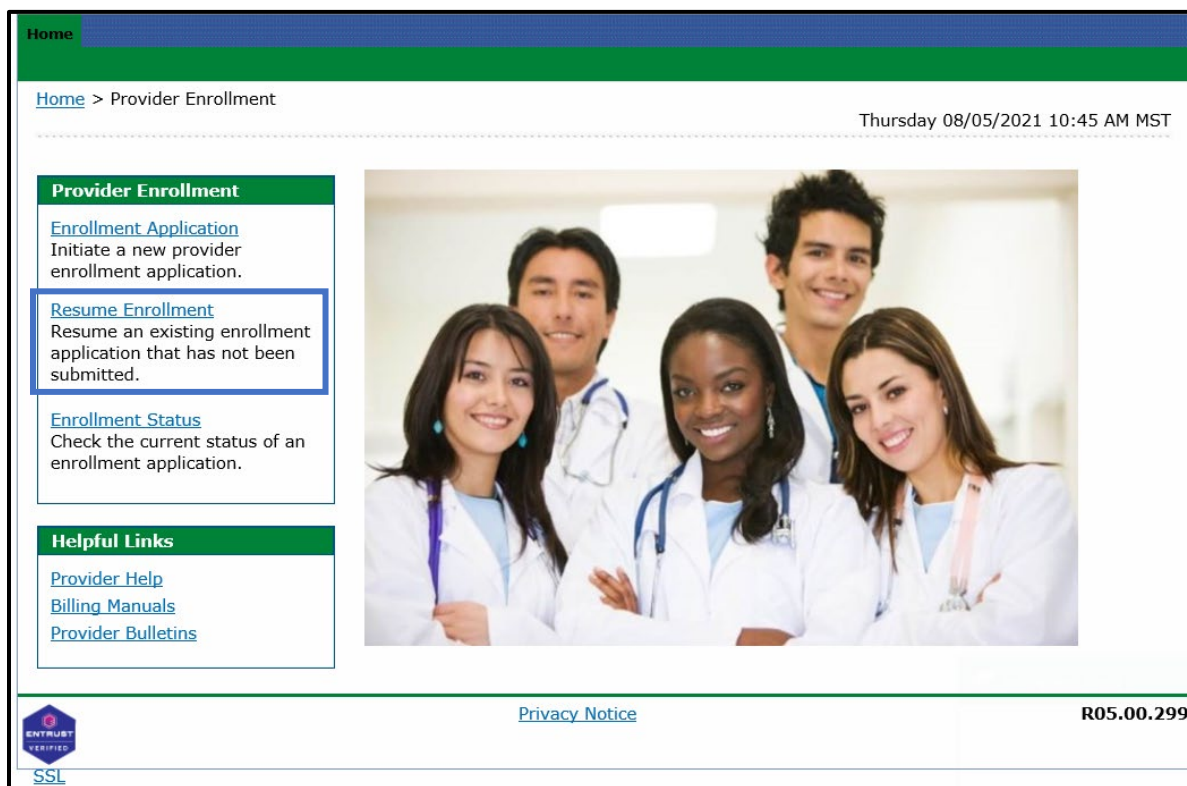
Additionally, providers may visit the [Provider Enrollment web page](#) for additional information.

## Resume Enrollment

If the user was unable to complete the enrollment process and elected to save the work, the application process can be resumed with the “Resume Enrollment” link as shown below. If the application was completed, but the user received an email from Gainwell Technologies stating additional or corrected information is needed, use the same link.

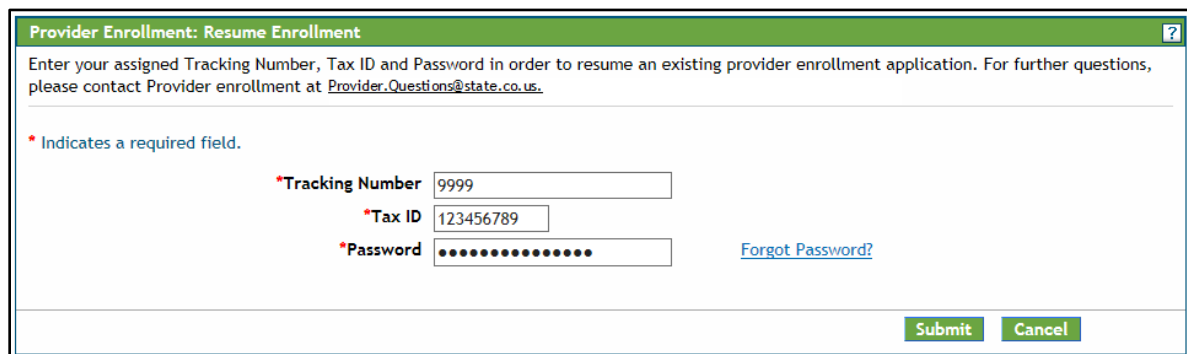
Unless an application is returned to a provider for updates or corrections, no changes may be made to information entered in the Provider Portal once the application is submitted.

### *Provider Portal - Resume Enrollment Link*



The screenshot shows the Provider Portal Home page. The top navigation bar is blue with a "Home" link. Below the navigation bar, the breadcrumb "Home > Provider Enrollment" is displayed. The date and time "Thursday 08/05/2021 10:45 AM MST" are shown in the top right. The main content area is divided into two columns. The left column contains three sections: "Provider Enrollment" with links for "Enrollment Application" (Initiate a new provider enrollment application), "Resume Enrollment" (Resume an existing enrollment application that has not been submitted), and "Enrollment Status" (Check the current status of an enrollment application). The right column features a large photograph of four healthcare professionals in white coats. Below the photograph, there is a "Privacy Notice" link and a "R05.00.299" identifier. The bottom of the page includes a "SSL" logo and a "Privacy Notice" link.

### *Provider Portal - Resume Enrollment - Login*



The screenshot shows the "Provider Enrollment: Resume Enrollment" login form. The form title is "Provider Enrollment: Resume Enrollment". The instructions state: "Enter your assigned Tracking Number, Tax ID and Password in order to resume an existing provider enrollment application. For further questions, please contact Provider enrollment at [Provider.Questions@state.co.us](mailto:Provider.Questions@state.co.us)." A note indicates that an asterisk (\*) denotes a required field. The form contains three input fields: "Tracking Number" with the value "9999", "Tax ID" with the value "123456789", and "Password" with masked characters. A "Forgot Password?" link is located next to the password field. At the bottom right, there are "Submit" and "Cancel" buttons.

The Tax ID entered here must be an exact match to the Tax ID that was entered as enrolling on the application.

# Enrollment Status

Using the “**Enrollment Status**” link shown below, providers may check the current status of their application.

## *Provider Portal - Enrollment Status Link*

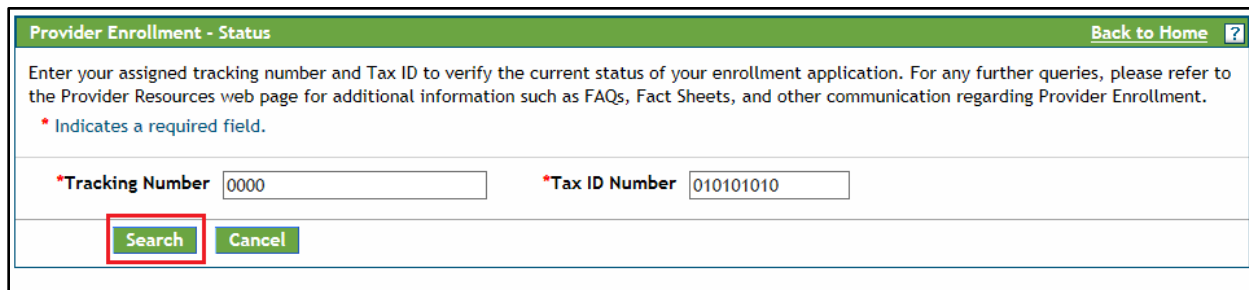


The screenshot shows a web interface for Provider Enrollment. On the left, there is a sidebar with three sections: 'Provider Enrollment', 'Helpful Links', and 'Enrollment Status'. The 'Enrollment Status' link is highlighted with a blue border. The main content area on the right features a photograph of five healthcare professionals (three women and two men) in white lab coats, smiling. The sidebar contains the following text:

- Provider Enrollment**
  - [Enrollment Application](#)  
Initiate a new provider enrollment application.
  - [Resume Enrollment](#)  
Resume an existing enrollment application that has not been submitted.
  - [Enrollment Status](#)  
Check the current status of an enrollment application.
- Helpful Links**
  - [Provider Help](#)
  - [Billing Manuals](#)
  - [Provider Bulletins](#)

## *Enrollment Status Login*

Click on the “**Enrollment Status**” link shown above. Enter the application tracking number (ATN) and tax ID number. Click the “**Search**” button:



The screenshot shows the 'Provider Enrollment - Status' login form. It includes a header bar with 'Provider Enrollment - Status' and a 'Back to Home' link. The main text area contains instructions: 'Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.' Below this, there is a note: '\* Indicates a required field.' The form has two input fields: '\*Tracking Number' with the value '0000' and '\*Tax ID Number' with the value '010101010'. At the bottom, there are two buttons: 'Search' (highlighted with a red border) and 'Cancel'.

The Provider Enrollment - Summary panel will then display showing the current status of the application:

### *Enrollment Status – Summary*

Home > [Provider Enrollment](#) > Enrollment Status

Tuesday 09/10/2019 07:04 PM MST

**Provider Enrollment - Status** [Back to Home](#) ?

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

\* Indicates a required field.

\*Tracking Number  \*Tax ID Number

[Search](#) [Cancel](#)

**Provider Enrollment - Summary**

Below is the status of your provider enrollment application. For any further queries, please refer to the [Provider Resources](#) web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

Tracking Number	223166
Date Submitted	09/10/2019
Status	Under Review
Status Date	09/10/2019

R05.00.295 [Privacy Notice](#)

Even if there are notes here indicating the application needs to be returned to the provider, the user **WILL NOT** be able to re-enter the application to make corrections until this status reads 'Returned to provider for Additional Information', 'Returned to provider for Additional Authorization(s)', or 'Returned to provider for Missing Documentation'.

Once the application is returned, an email is sent to the contact email address from the application, to notify contact of the status.

To make the required corrections the user will need to log back into the application by clicking [Resume Enrollment \(See previous section\)](#). The user will then need to press the continue button at the bottom of each panel to navigate through the application.

## Site Visits

Per federal requirement 42CFR 455.432, pre-enrollment site visits of providers who are designated as “moderate” or “high” categorical risks to the Medicaid program are required.

The purpose is to verify that the information submitted to the Department of Health Care Policy and Financing by a provider is accurate and to determine compliance with federal and state enrollment requirements. In the event that the provider type falls into one of these risk categories, the user will be contacted for the required site visit. A representative will visit the service location to verify certain aspects of the enrollment. Providers that refuse a site visit may be excluded from the Colorado Medicaid Program.

For further information about risk categories by provider type, please refer to the risk levels on the [Information by Provider Type web page](#).

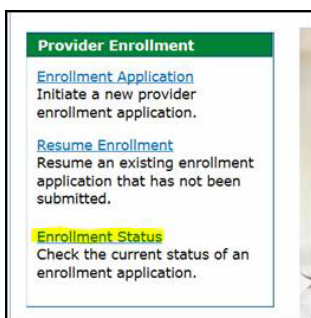
# File a Grievance

If the application is denied for enrollment, and the provider disagrees with the decision, follow the process to file a grievance.

1. Go to [Provider Enrollment Portal Home page](#).
2. Select this box.



3. Select the "Enrollment Status" link.



4. Enter the Tracking Number (ATN) and Tax ID Number from the ATN and then click the "Search" button.

A screenshot of a web interface showing a form titled "Provider Enrollment - Status". The form contains the following text: "Enter your assigned tracking number and Tax ID to verify the current status of your enrollment queries, please refer to the Provider Resources web page for additional information such as F communication regarding Provider Enrollment." Below this text is a red asterisk followed by the text "Indicates a required field." The form has two input fields: "\*Tracking Number" and "\*Tax ID Number". Below the input fields are two buttons: "Search" and "Cancel".

5. Scroll to the bottom of the page and select link "Click here to submit a grievance".

A screenshot of a web interface showing the bottom of the page. It contains a table with the following content:

Reason
<b>Notes</b> 07/23/2018: RTP- -Proof of Accreditation of Medical Transport Systems (CAMTS) or a successor Required.
If you disagree with this outcome and want to appeal this decision <a href="#">Click here to submit a grievance</a>

6. Enter the reason for disagreeing with the decision and click the **“Submit”** button.

NOTE: Only the first 500 characters will be saved with this Grievance Request.

**\*Comments** Please re-open for processing.

**Submit** **Cancel**

7. The grievance has been filed.
8. The grievance will be reviewed by Gainwell Technologies and the provider will receive the following notification once the grievance has been approved.
9. The application is now back in “Under Review” status and will be reviewed again by Gainwell Technologies analyst.

# Provider Enrollment Notifications

The applicant will receive several notifications via email during the Enrollment Process:

- Upon successful submission of an online enrollment application for review, the applicant will receive an email at the email address entered in the contact information during the enrollment process acknowledging the submission.
- During the application review process by Gainwell Technologies, if additional information and/or missing documentation is needed, an email will be sent to the email address entered in the contact information during the enrollment process. The applicant will then be able to return to the application on the web portal to address the issues through the “Resume Enrollment” link. Once this is completed, Gainwell Technologies will be notified of the application update and will continue processing.
- Once the application has been reviewed another email will be sent to the address entered in the contact information during the enrollment process advising the applicant of the outcome.
  - If the application is approved, the user will be advised that they are enrolled but that they must complete certain steps with the current fiscal agent in order to begin billing for services.
    - Once the application has been approved for enrollment, the user will receive instructions for registering their assigned provider ID number in the provider web portal. Registration instructions may also be viewed in the [Provider Web Portal Registration Quick Guide web page](#).  
Note: PACE-Only Subcontractors cannot register for the Provider Web Portal and must contact the [Provider Services Call Center](#) to update their provider information or disenroll.
  - If the application is rejected, the user will be advised of the reason and their rights to file a grievance. See the File to Grievance section for more information.



# Forms

To access any applicable forms that may need to be printed, completed, signed and uploaded to the enrollment application, visit the [Provider Forms web page](#) and select the Provider Enrollment & Update Forms drop-down.