Provider Enrollment

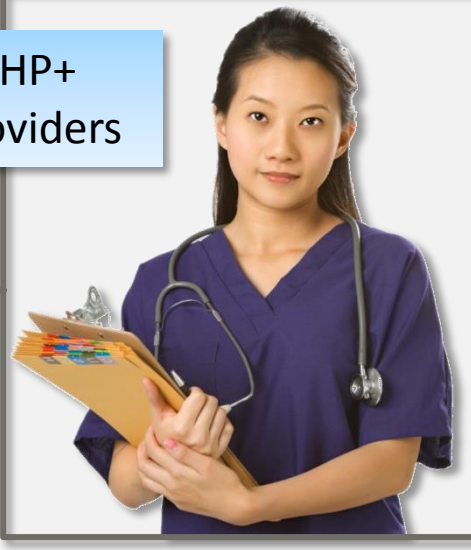
Colorado Medicaid
2014

Centers for Medicare & Medicaid Services

Department of Health Care Policy and Financing

Medicaid

Medicaid/CHP+ Medical Providers



Xerox State Healthcare

Training Objectives

- Understand how to become a Medicaid Provider
- Who needs to enroll?
  - Rendering vs. Billing provider
- Application
- Enrollment
- Billing Preview
- Know where to find reference material

Becoming a Medicaid Provider

- In order to enroll as Medicaid Provider:
  - Download, complete, submit Provider Enrollment Application:
    - Include NPI, licensure, & insurance
    - Include all other required documents from the Provider Application Checklist

Provider Enrollment

Question:

Who needs to enroll with
Colorado Medical Assistance Program?

Answer:

Everyone who provides services for
Colorado Medical Assistance Program members

Rendering Versus Billing

Rendering Provider

- Individual that provides services to a Medicaid member

Billing Provider

- Entity being reimbursed for service

Provider vs. Rendering Application

Standard Provider Application

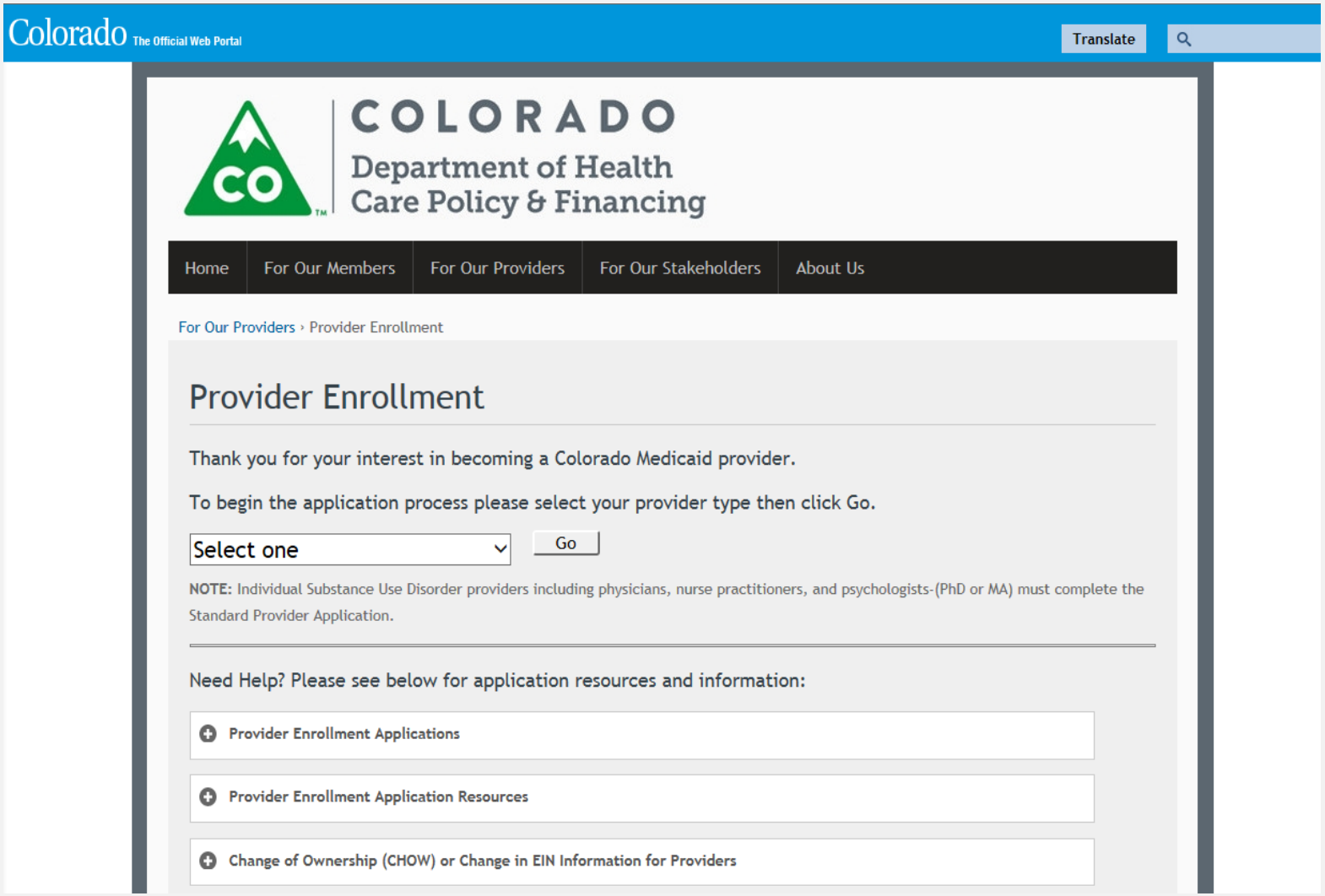
- Most often requires the use of an EIN
- Direct pay or billing entity
- Payments reported to the IRS

Rendering Provider Application

- Enrollment requires SSN only
- Individual providing services to a Medicaid member
- Indirect pay entity - receives payments through a billing entity

NEW! Department Website

Enrollment Documents



Completing the Application

- The following slides show how to complete each page of the Standard Provider Application
  - Similar blocks in the Standard Provider Application can be referenced to complete the Rendering Provider Application

Change of Ownership (CHOW) or Federal Employer Identification Number (EIN)

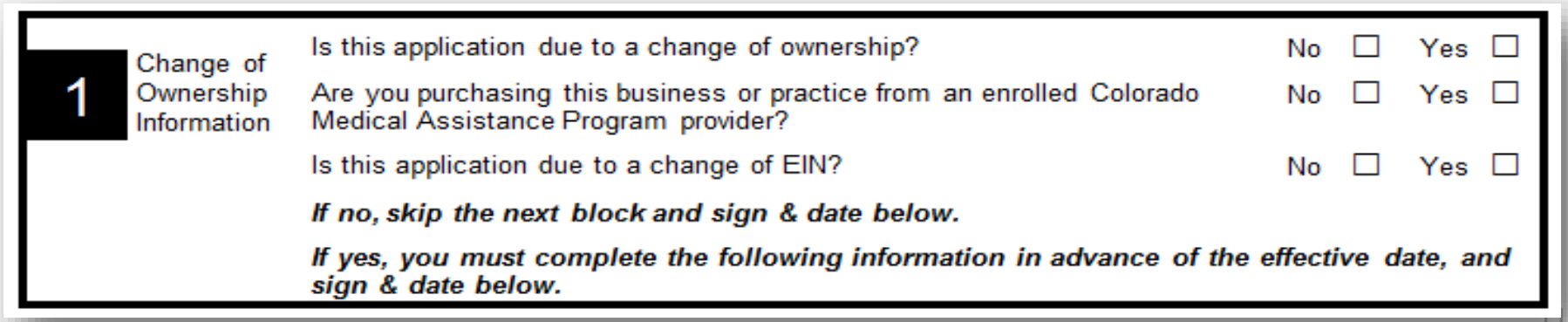
Indicate if the application is a result of a change of ownership or change of EIN

Yes

- Complete required information
- Sign and date at bottom of page

No

- Check "No"
- Sign and date at bottom of page



1	Change of Ownership Information	Is this application due to a change of ownership?	No ☐	Yes ☐
		Are you purchasing this business or practice from an enrolled Colorado Medical Assistance Program provider?	No ☐	Yes ☐
		Is this application due to a change of EIN?	No ☐	Yes ☐
		If no, skip the next block and sign & date below.		
		If yes, you must complete the following information in advance of the effective date, and sign & date below.		

Change of Ownership (CHOW) or Federal Employer Identification Number (EIN)

- All providers must contact Provider Enrollment prior to the effective date
  - New owners cannot use previous owner's provider number
  - New provider number must be assigned prior to new claim submissions
  - New NPI may be required

Name & Business Organization Information

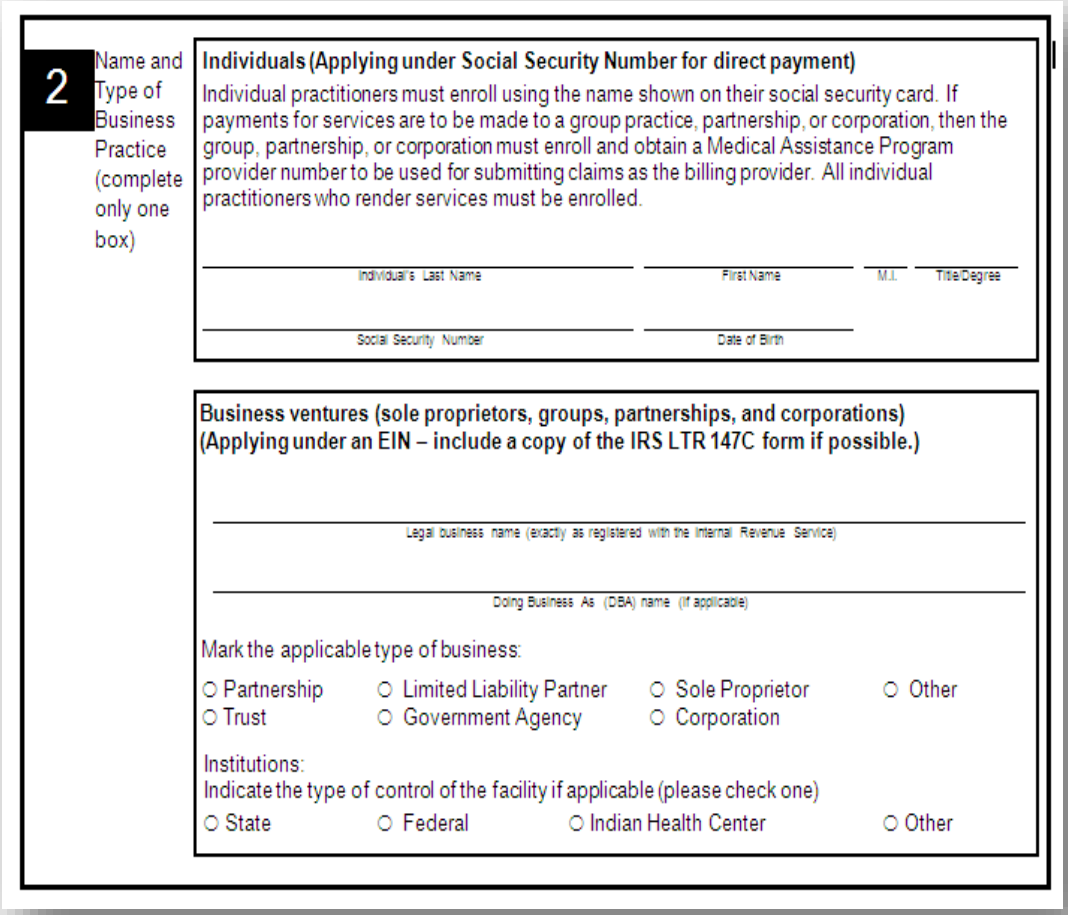
Individual (SSN)

- Enter Individual's name & information

OR

Group (EIN)

- Complete Business Venture section
- Include copy of IRS LTR 147C (if available)



2 Name and Type of Business Practice (complete only one box)

Individuals (Applying under Social Security Number for direct payment)

Individual practitioners must enroll using the name shown on their social security card. If payments for services are to be made to a group practice, partnership, or corporation, then the group, partnership, or corporation must enroll and obtain a Medical Assistance Program provider number to be used for submitting claims as the billing provider. All individual practitioners who render services must be enrolled.

Individual's Last Name | First Name | M.I. | Title/Degree

Social Security Number | Date of Birth

Business ventures (sole proprietors, groups, partnerships, and corporations) (Applying under an EIN – include a copy of the IRS LTR 147C form if possible.)

Legal business name (exactly as registered with the Internal Revenue Service)

Doing Business As (DBA) name (if applicable)

Mark the applicable type of business:

○ Partnership ○ Limited Liability Partner ○ Sole Proprietor ○ Other
○ Trust ○ Government Agency ○ Corporation

Institutions:
Indicate the type of control of the facility if applicable (please check one)

○ State ○ Federal ○ Indian Health Center ○ Other

Name and Business Organization Information

Section 3 – Medicaid Participation Information

- Check Yes or No
- If "Yes" - **complete each question**

3 Medicaid Participation

Are you currently enrolled in the Title XIX (Medicaid) program or CHIP of any other state(s)?
Yes ☐ No ☐ If Yes, which states? _____

Are you currently applying for enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s)?
Yes ☐ No ☐ If Yes, which states? _____

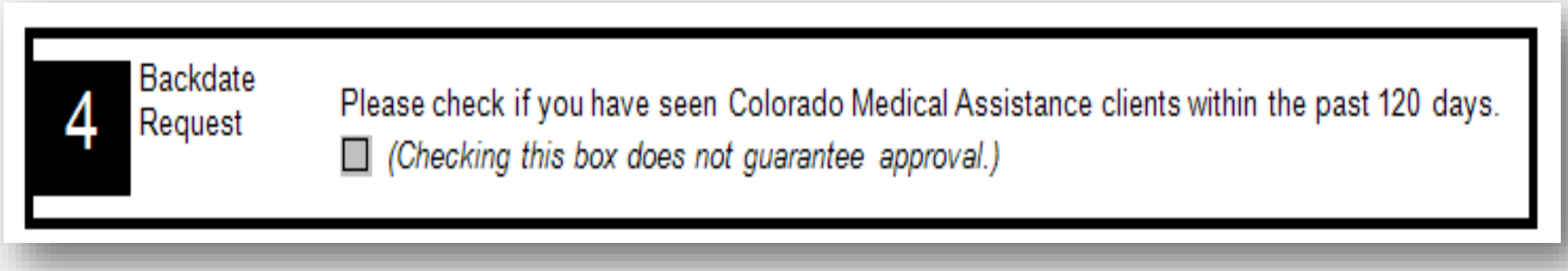
Have you ever been denied enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s)?
Yes ☐ No ☐ If Yes, which states and when? _____

Has your enrollment in the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated?
Yes ☐ No ☐ If Yes, which states and when? _____

Name and Business Organization Information

Section 4 – Backdate Request

- Check box to request backdate
- Approval **not** guaranteed

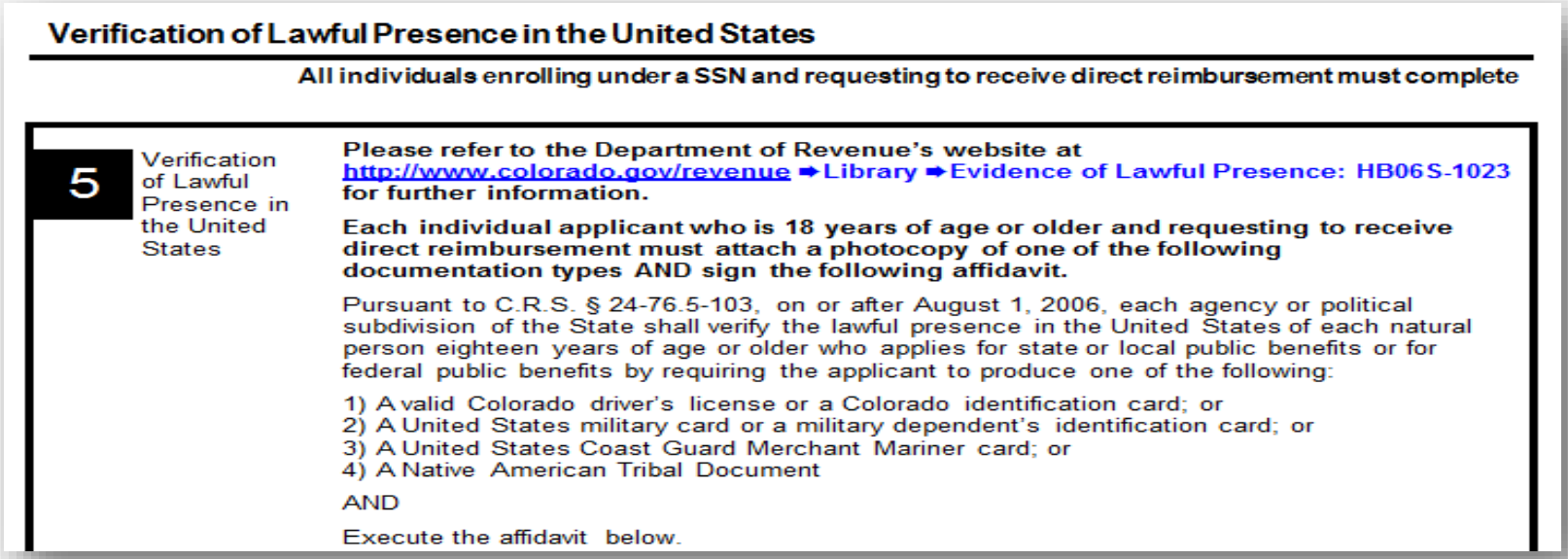


Lawful Presence Verification

Each applicant who is 18 years of age or older, requesting to receive direct reimbursement under his/her SSN must attach:

- a completed lawful presence verification affidavit
- a copy of identification (possible identification documents as listed)

Note: Providers enrolling with an EIN are **not** required to complete this section



Verification of Lawful Presence in the United States

All individuals enrolling under a SSN and requesting to receive direct reimbursement must complete

5 Verification of Lawful Presence in the United States

Please refer to the Department of Revenue's website at http://www.colorado.gov/revenue ➡ Library ➡ Evidence of Lawful Presence: HB06S-1023 for further information.

Each individual applicant who is 18 years of age or older and requesting to receive direct reimbursement must attach a photocopy of one of the following documentation types AND sign the following affidavit.

Pursuant to C.R.S. § 24-76.5-103, on or after August 1, 2006, each agency or political subdivision of the State shall verify the lawful presence in the United States of each natural person eighteen years of age or older who applies for state or local public benefits or for federal public benefits by requiring the applicant to produce one of the following:

1) A valid Colorado driver's license or a Colorado identification card; or
2) A United States military card or a military dependent's identification card; or
3) A United States Coast Guard Merchant Mariner card; or
4) A Native American Tribal Document

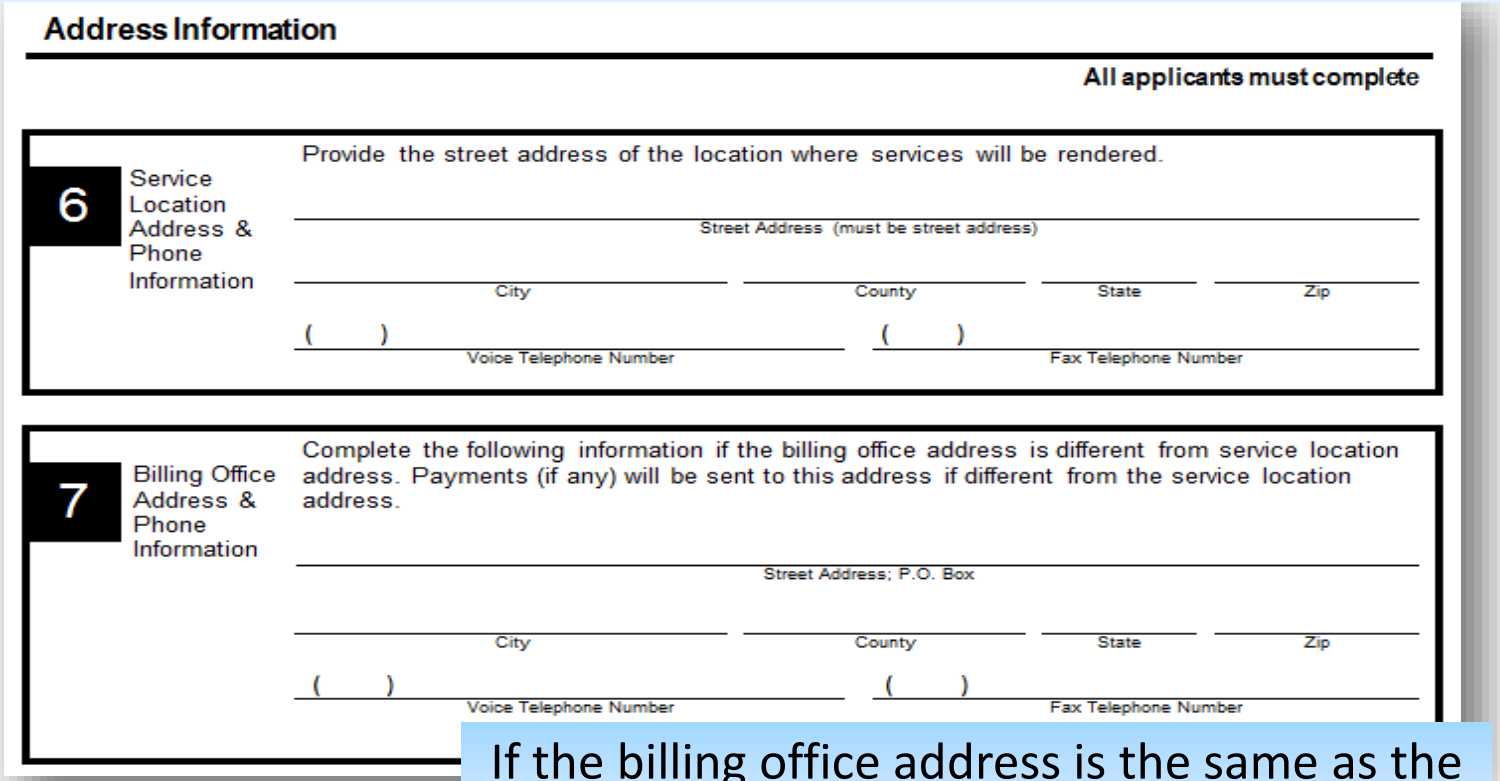
AND

Execute the affidavit below.

Provider Address Information

Without service location address applications will be considered **incomplete**

- PO Boxes or Intersections are **not** acceptable



Address Information

All applicants must complete

6 Service Location Address & Phone Information

Provide the street address of the location where services will be rendered.

Street Address (must be street address)

City | County | State | Zip

( ) Voice Telephone Number | ( ) Fax Telephone Number

7 Billing Office Address & Phone Information

Complete the following information if the billing office address is different from service location address. Payments (if any) will be sent to this address if different from the service location address.

Street Address; P.O. Box

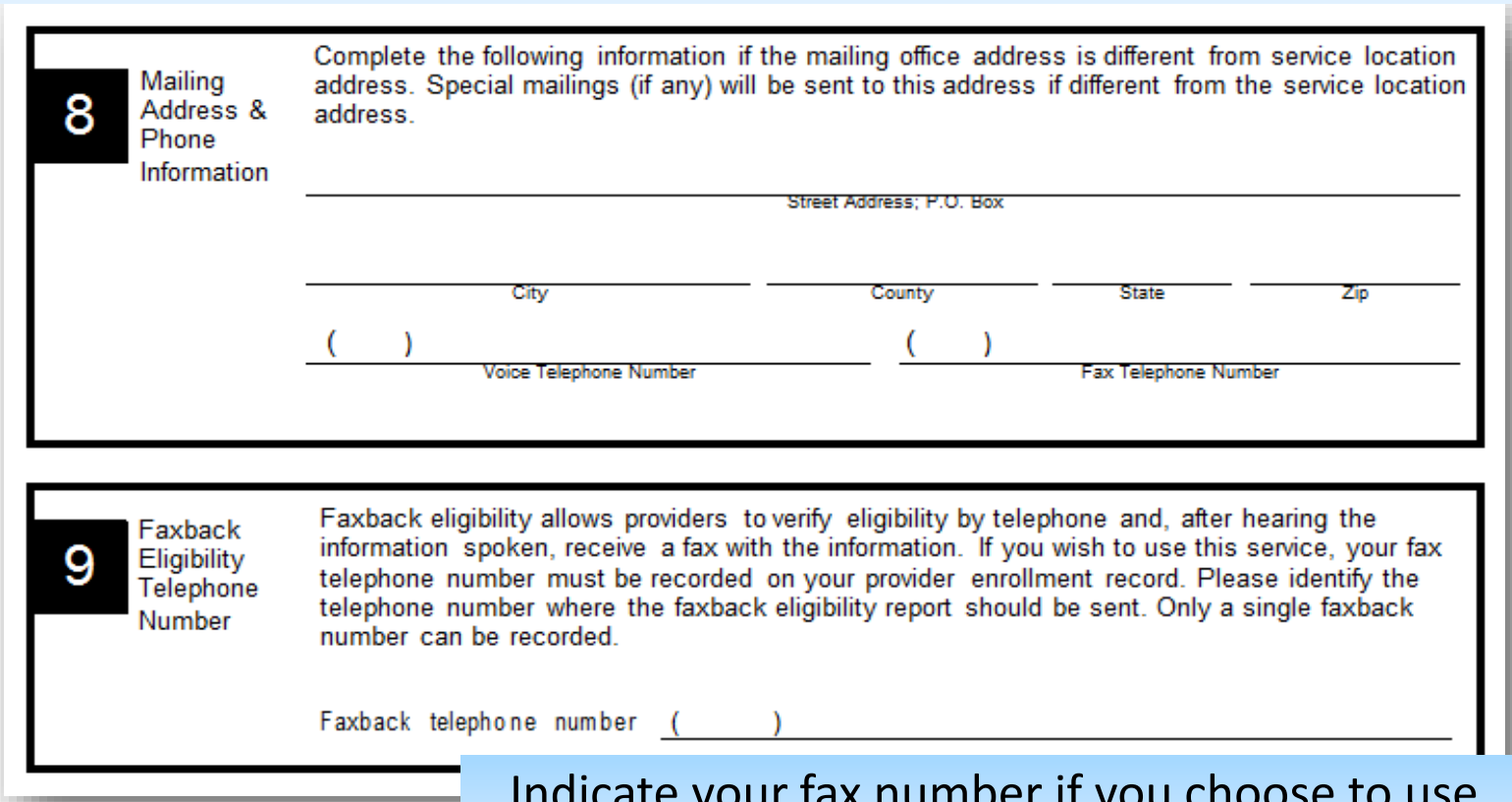
City | County | State | Zip

( ) Voice Telephone Number | ( ) Fax Telephone Number

If the billing office address is the same as the service location, indicate “Same”

Provider Address Information

If the mailing address is the same as the service location, indicate “Same”



8 Mailing Address & Phone Information

Complete the following information if the mailing office address is different from service location address. Special mailings (if any) will be sent to this address if different from the service location address.

Street Address; P.O. Box

City | County | State | Zip

( ) Voice Telephone Number

( ) Fax Telephone Number

9 Faxback Eligibility Telephone Number

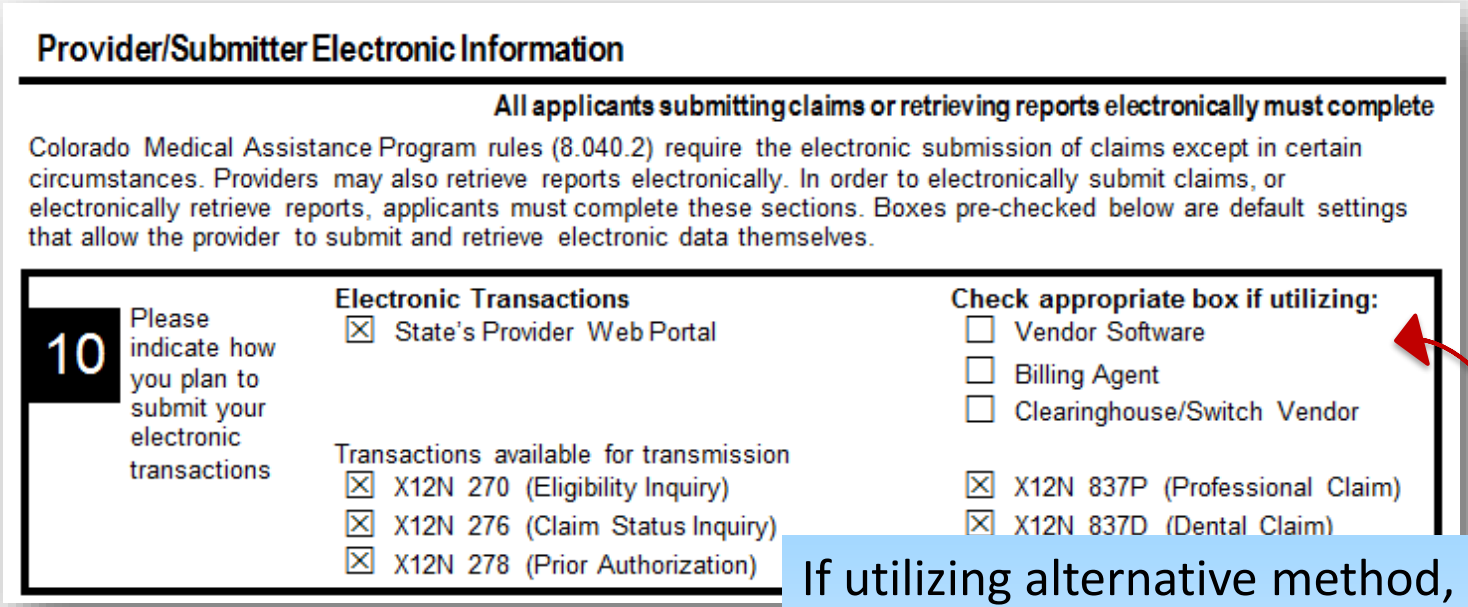
Faxback eligibility allows providers to verify eligibility by telephone and, after hearing the information spoken, receive a fax with the information. If you wish to use this service, your fax telephone number must be recorded on your provider enrollment record. Please identify the telephone number where the faxback eligibility report should be sent. Only a single faxback number can be recorded.

Faxback telephone number ( )

Indicate your fax number if you choose to use the member eligibility faxback service

Provider/Submitter Electronic Information

Boxes are pre-checked for applicants, using the Colorado Medical Assistance Program Web Portal, to submit & retrieve electronic data for themselves



Provider/Submitter Electronic Information

All applicants submitting claims or retrieving reports electronically must complete

Colorado Medical Assistance Program rules (8.040.2) require the electronic submission of claims except in certain circumstances. Providers may also retrieve reports electronically. In order to electronically submit claims, or electronically retrieve reports, applicants must complete these sections. Boxes pre-checked below are default settings that allow the provider to submit and retrieve electronic data themselves.

10 Please indicate how you plan to submit your electronic transactions

Electronic Transactions

☒ State's Provider Web Portal

Transactions available for transmission

☒ X12N 270 (Eligibility Inquiry)

☒ X12N 276 (Claim Status Inquiry)

☒ X12N 278 (Prior Authorization)

Check appropriate box if utilizing:

☐ Vendor Software

☐ Billing Agent

☐ Clearinghouse/Switch Vendor

☒ X12N 837P (Professional Claim)

☒ X12N 837D (Dental Claim)

If utilizing alternative method, check appropriate box

- ❑ Vendor Software
- ❑ Billing Agent
- ❑ Clearinghouse

Electronic Report Response Retrieval

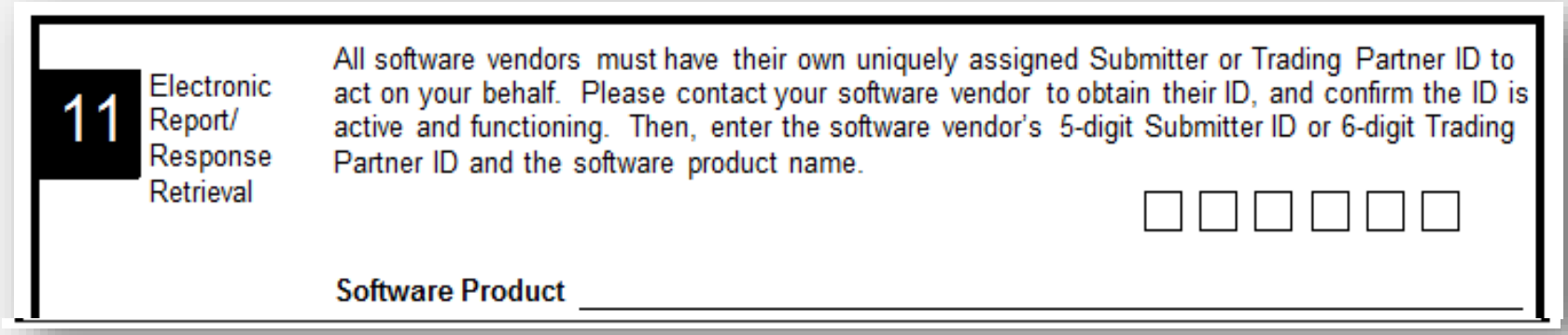
All billing providers are required to have Trading Partner (TP) ID number

Applicants using billing agent/clearinghouse or vendor software

- Enter their 5-digit submitter ID **or** 6-digit TPID in second set of boxes
- Write product name on the line

All other applicants

- TPID will be issued to you upon approval of your application
- Do not enter anything in first box



11 Electronic Report/ Response Retrieval

All software vendors must have their own uniquely assigned Submitter or Trading Partner ID to act on your behalf. Please contact your software vendor to obtain their ID, and confirm the ID is active and functioning. Then, enter the software vendor's 5-digit Submitter ID or 6-digit Trading Partner ID and the software product name.

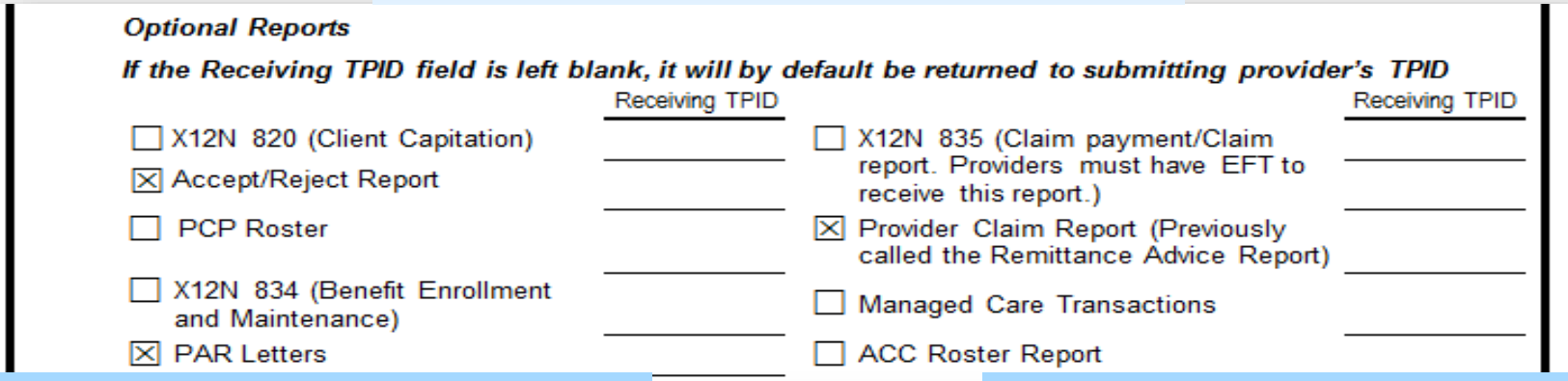
☐☐☐☐☐☐

Software Product _____

Electronic Report Response Retrieval

Optional Reports

- Select additional reports as needed
- Reports can only be sent to one (1) ID



Optional Reports

If the Receiving TPID field is left blank, it will by default be returned to submitting provider's TPID

	Receiving TPID		Receiving TPID
☐ X12N 820 (Client Capitation)		☐ X12N 835 (Claim payment/Claim report. Providers must have EFT to receive this report.)	
☒ Accept/Reject Report			
☐ PCP Roster		☒ Provider Claim Report (Previously called the Remittance Advice Report)	
☐ X12N 834 (Benefit Enrollment and Maintenance)		☐ Managed Care Transactions	
☒ PAR Letters		☐ ACC Roster Report	

Indicate if a report should be delivered directly to the:

- Provider's TPID
- Billing Agent's TPID
- Clearinghouse's TPID

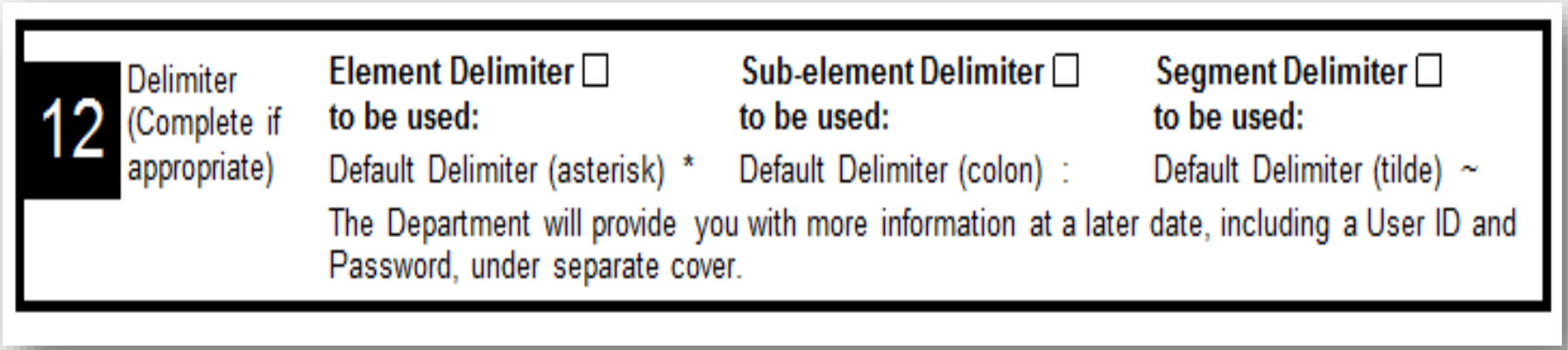
If newly enrolling (awaiting assigned TPID)

- Note "pending" in space for Receiving TPID

Provider/Submitter Electronic Information

Delimiter

- Usually used by billing agent/clearinghouse or software vendor
- Select preference as to how data will be divided
  - ie: the comma character, which acts as a field delimiter in a sequence of comma-separated values



12	Delimiter (Complete if appropriate)	Element Delimiter ☐ to be used:	Sub-element Delimiter ☐ to be used:	Segment Delimiter ☐ to be used:
		Default Delimiter (asterisk) *	Default Delimiter (colon) :	Default Delimiter (tilde) ~
		The Department will provide you with more information at a later date, including a User ID and Password, under separate cover.		

Provider/Submitter Electronic Information

Primary contact - the individual authorized to manage the State's Provider Web Portal

Note: If primary contact information is not provided, application will be considered incomplete

13 Web Portal Contact Information

Primary Contact Information/Trading Partner Administrator

Contact Individual Name: _____ (First Name) _____ (Last Name) _____ (Title)

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Fax: ( ) _____

Business email address: _____

Secondary Contact Information/Trading Partner Administrator

Contact Individual Name: _____ (First Name) _____ (Last Name) _____ (Title)

Business Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Fax: ( ) _____

Business email address: _____

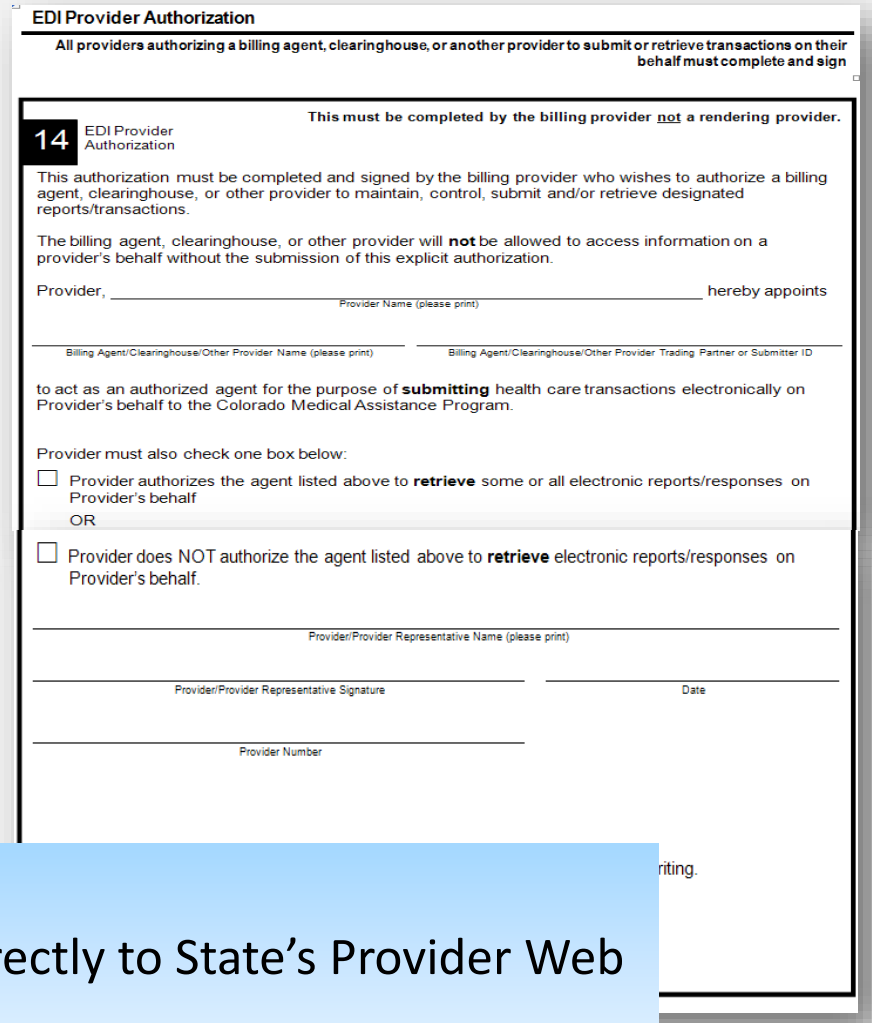
EDI Provider Authorization

To be completed by:

- applicant authorizing third party to submit transactions & retrieve electronic reports/ responses

Don't forget to provide a signature

- Individual must sign and date
- For group application, an authorized person must sign and date



EDI Provider Authorization

All providers authorizing a billing agent, clearinghouse, or another provider to submit or retrieve transactions on their behalf must complete and sign

This must be completed by the billing provider not a rendering provider.

14 EDI Provider Authorization

This authorization must be completed and signed by the billing provider who wishes to authorize a billing agent, clearinghouse, or other provider to maintain, control, submit and/or retrieve designated reports/transactions.

The billing agent, clearinghouse, or other provider will **not** be allowed to access information on a provider's behalf without the submission of this explicit authorization.

Provider, _____ hereby appoints
Provider Name (please print)

_____ _____
Billing Agent/Clearinghouse/Other Provider Name (please print) | Billing Agent/Clearinghouse/Other Provider Trading Partner or Submitter ID

to act as an authorized agent for the purpose of **submitting** health care transactions electronically on Provider's behalf to the Colorado Medical Assistance Program.

Provider must also check one box below:

☐ Provider authorizes the agent listed above to **retrieve** some or all electronic reports/responses on Provider's behalf

OR

☐ Provider does NOT authorize the agent listed above to **retrieve** electronic reports/responses on Provider's behalf.

_____
Provider/Provider Representative Name (please print)

_____ _____
Provider/Provider Representative Signature | Date

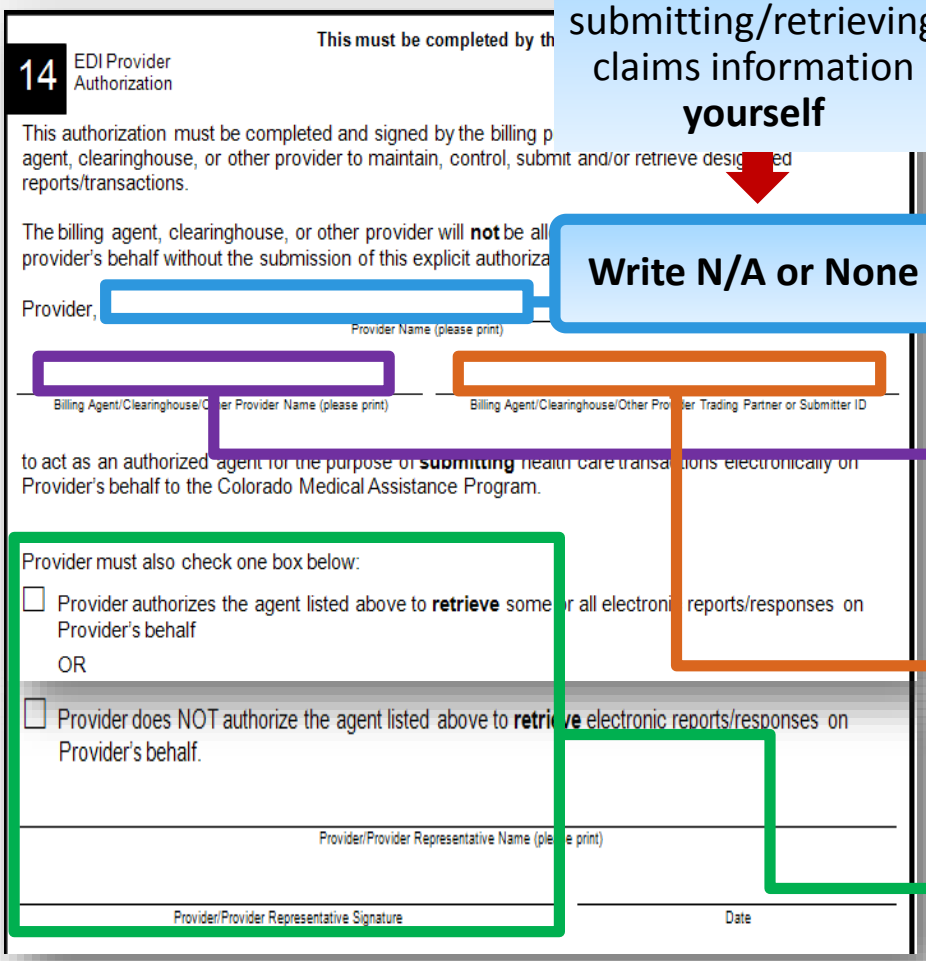
_____
Provider Number

riting.

Do not complete if:

- applicants submitting own claims directly to State's Provider Web Portal

EDI Provider Authorization - Instructions



If you will be submitting/retrieving claims information **yourself**

If you are a **Group** authorizing third party billing

If you are an **Individual** authorizing third party billing

Write N/A or None

Enter the enrolling **individual's** name

Enter the enrolling **group's** name

Enter billing agent, clearinghouse or other billing provider **name**

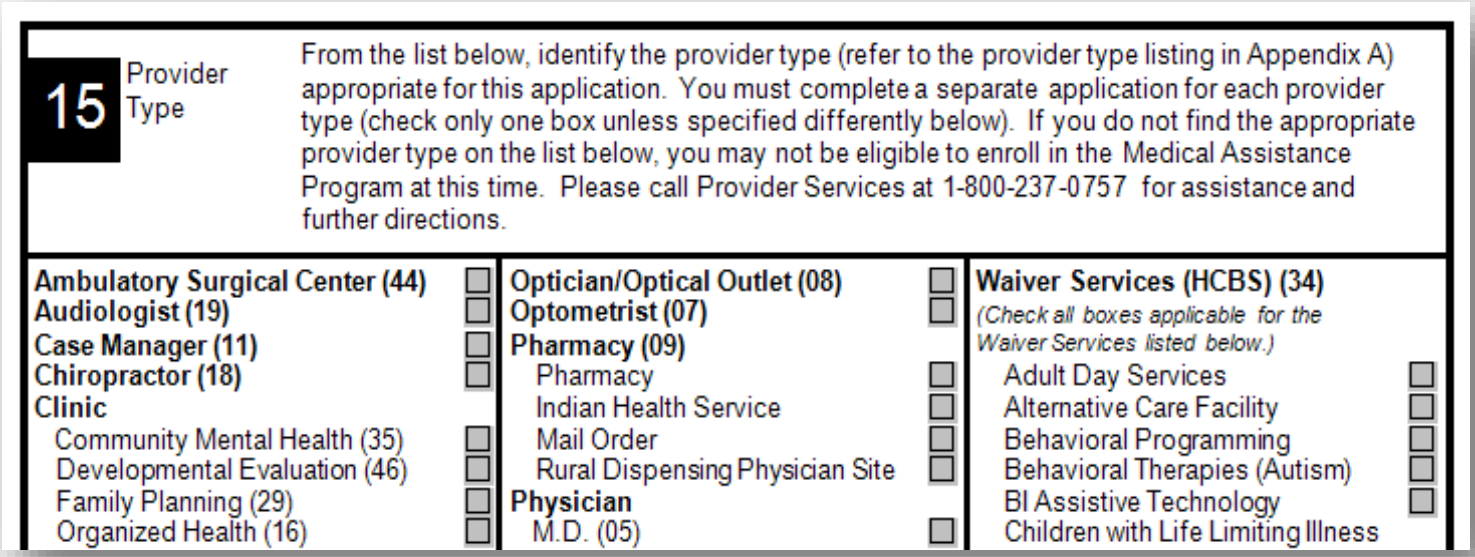
Enter billing agent, clearinghouse or other provider's trading partner or submitter **ID**

Don't forget to **check** the appropriate box and provide **signature**

Provider Type

Section 15 - Provider Type

- Indicate provider type for applicant
- Only one box can be checked, per application
  - ➢ Separate application must be completed for each provider type **unless** Waiver Services (HCBS)



15 Provider Type

From the list below, identify the provider type (refer to the provider type listing in Appendix A) appropriate for this application. You must complete a separate application for each provider type (check only one box unless specified differently below). If you do not find the appropriate provider type on the list below, you may not be eligible to enroll in the Medical Assistance Program at this time. Please call Provider Services at 1-800-237-0757 for assistance and further directions.

Ambulatory Surgical Center (44) ☐
Audiologist (19) ☐
Case Manager (11) ☐
Chiropractor (18) ☐
Clinic
- Community Mental Health (35) ☐
- Developmental Evaluation (46) ☐
- Family Planning (29) ☐
- Organized Health (16) ☐

Optician/Optical Outlet (08) ☐
Optometrist (07) ☐
Pharmacy (09)
- Pharmacy ☐
- Indian Health Service ☐
- Mail Order ☐
- Rural Dispensing Physician Site ☐

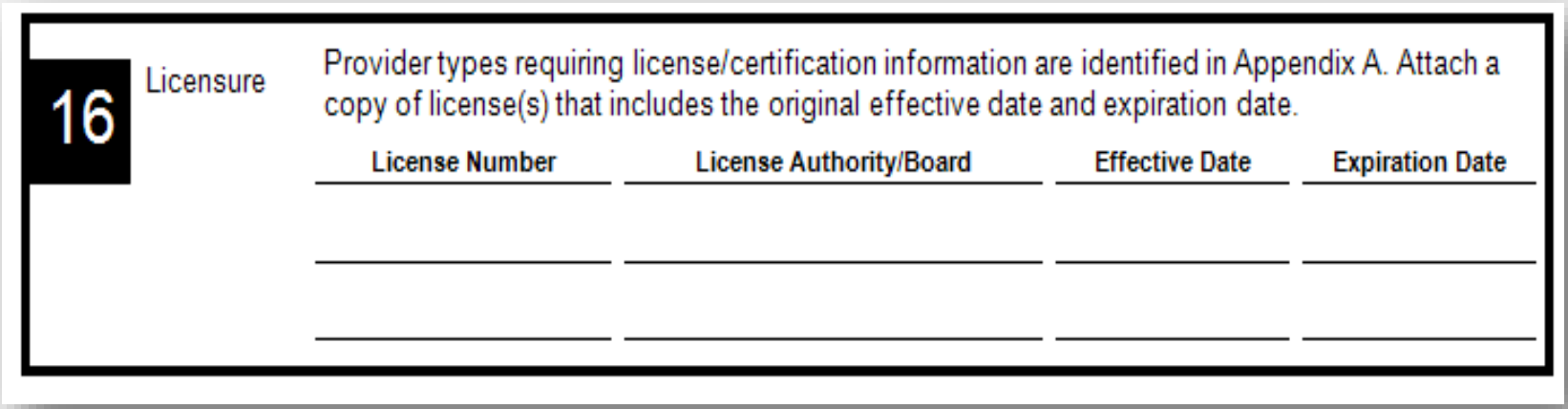
Physician
- M.D. (05) ☐

Waiver Services (HCBS) (34)
(Check all boxes applicable for the Waiver Services listed below.)
- Adult Day Services ☐
- Alternative Care Facility ☐
- Behavioral Programming ☐
- Behavioral Therapies (Autism) ☐
- BI Assistive Technology ☐
- Children with Life Limiting Illness

Licensure

Section 16 - Licensure

- All Individual applicants must submit a license
  - Effective and expiration dates **must** be documented on license
  - If either date is missing, application is **incomplete**
- Groups that require sales tax license or facility license (Medicare Survey License) must also attach these licenses



16 Licensure

Provider types requiring license/certification information are identified in Appendix A. Attach a copy of license(s) that includes the original effective date and expiration date.

License Number	License Authority/Board	Effective Date	Expiration Date

Practitioner Specialty Information

Section 17 – Practitioner Specialty Information

- All board certified practitioners should complete

17 Practitioner Specialty

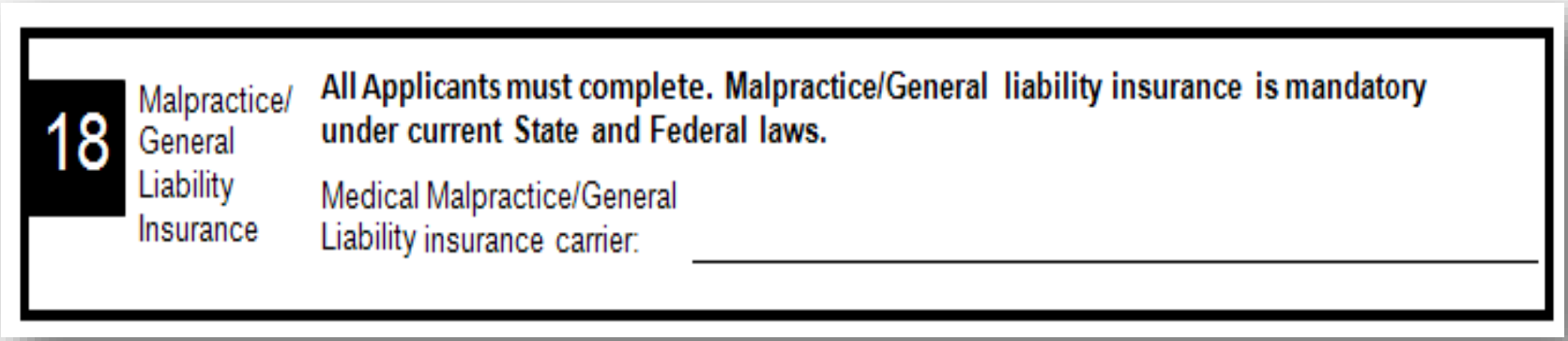
If board certified, please provide the specialty board certification number, effective date, and expiration date of certification. If needed, provide additional information on the reverse or attach additional pages.

Specialty	Certificate Number	Effective Date	Expiration Date

Insurance

Section 18 – Malpractice/General Liability Information

- Required for all applicants
- Must submit copy of insurance



18	Malpractice/ General Liability Insurance	**All Applicants must complete. Malpractice/General liability insurance is mandatory under current State and Federal laws.**
		Medical Malpractice/General Liability insurance carrier: _____

Registration Information

Section 19 – Pharmacy Registration Information

- Required for Pharmacy only

19 Pharmacy Registration

Pharmacy applicants must complete. ***Failure to complete this section may affect reimbursement rates.***

National Council on Prescription Drug Programs (NCPDP) number (7 digit number)
(Formerly National Association of Board Pharmacies (NABP) number) _____

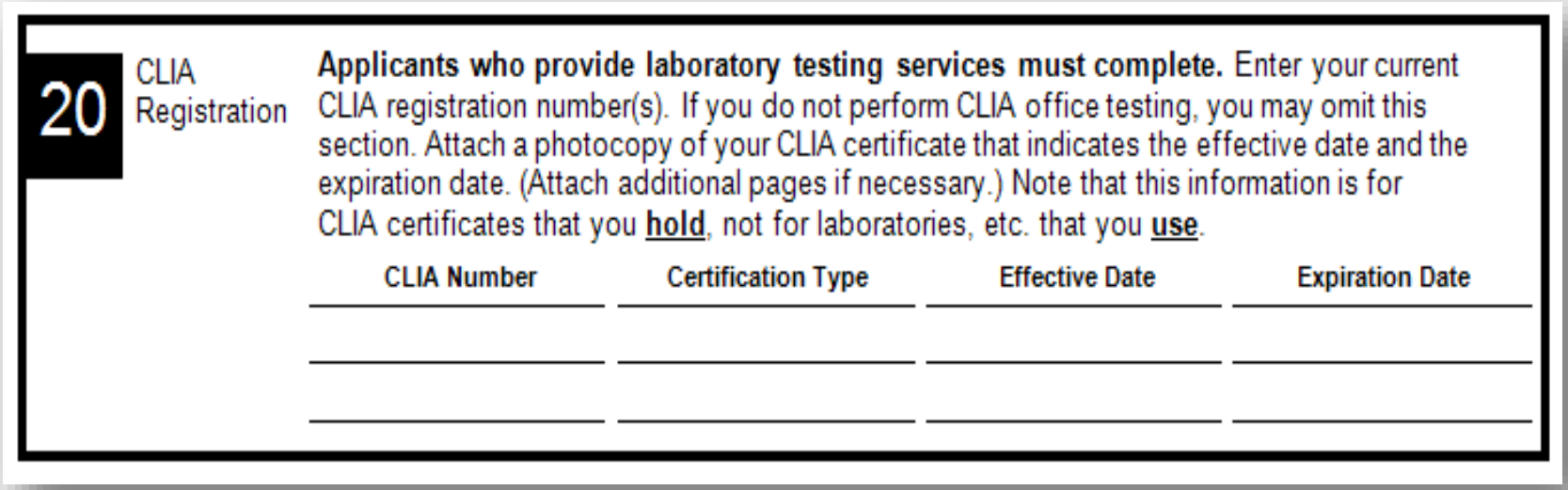
Pharmacy classification (check one)

☐ Metro (independent)	☐ State Government	☐ Mail Order
☐ Rural (Independent)	☐ 340B	
☐ Hospital	Federal Government	
☐ Chain	☐ Hospital	
☐ Specialty/Infusion	☐ Retail	

Registration Information

Section 20 – CLIA Registration Information

- Required to provide laboratory testing services
- Must submit copy of certification



20 CLIA Registration

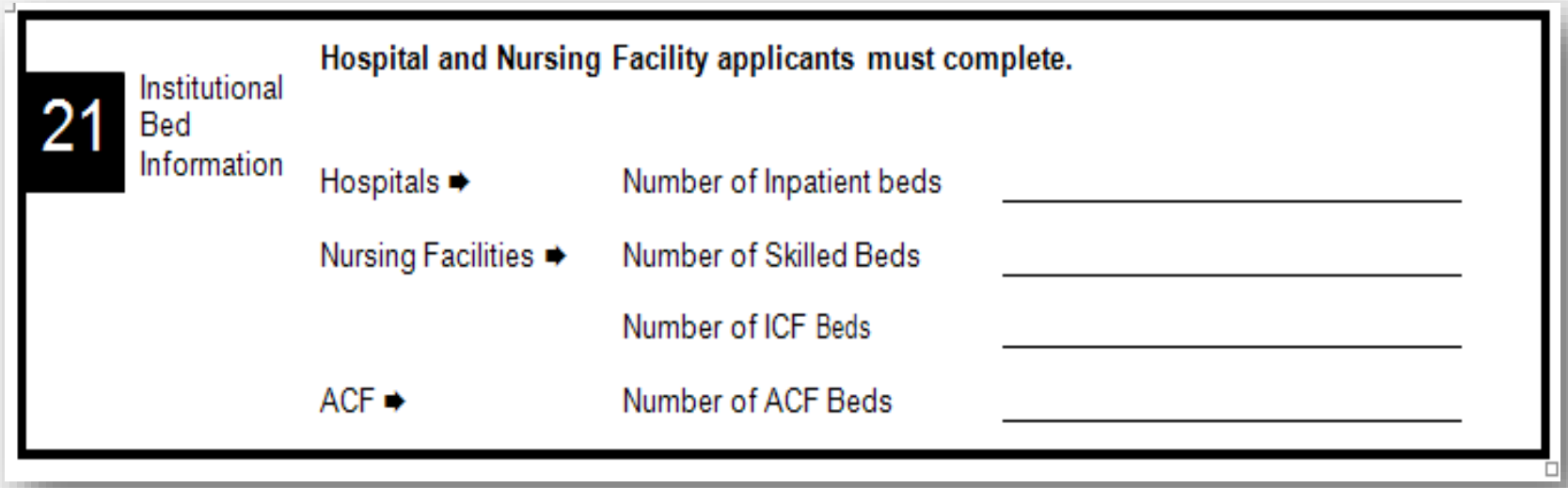
Applicants who provide laboratory testing services must complete. Enter your current CLIA registration number(s). If you do not perform CLIA office testing, you may omit this section. Attach a photocopy of your CLIA certificate that indicates the effective date and the expiration date. (Attach additional pages if necessary.) Note that this information is for CLIA certificates that you **hold**, not for laboratories, etc. that you **use**.

CLIA Number	Certification Type	Effective Date	Expiration Date

Registration Information

Section 21 – Institutional Bed Information

- To be completed by hospitals, nursing facilities, and alternative care facilities only



21 Institutional Bed Information

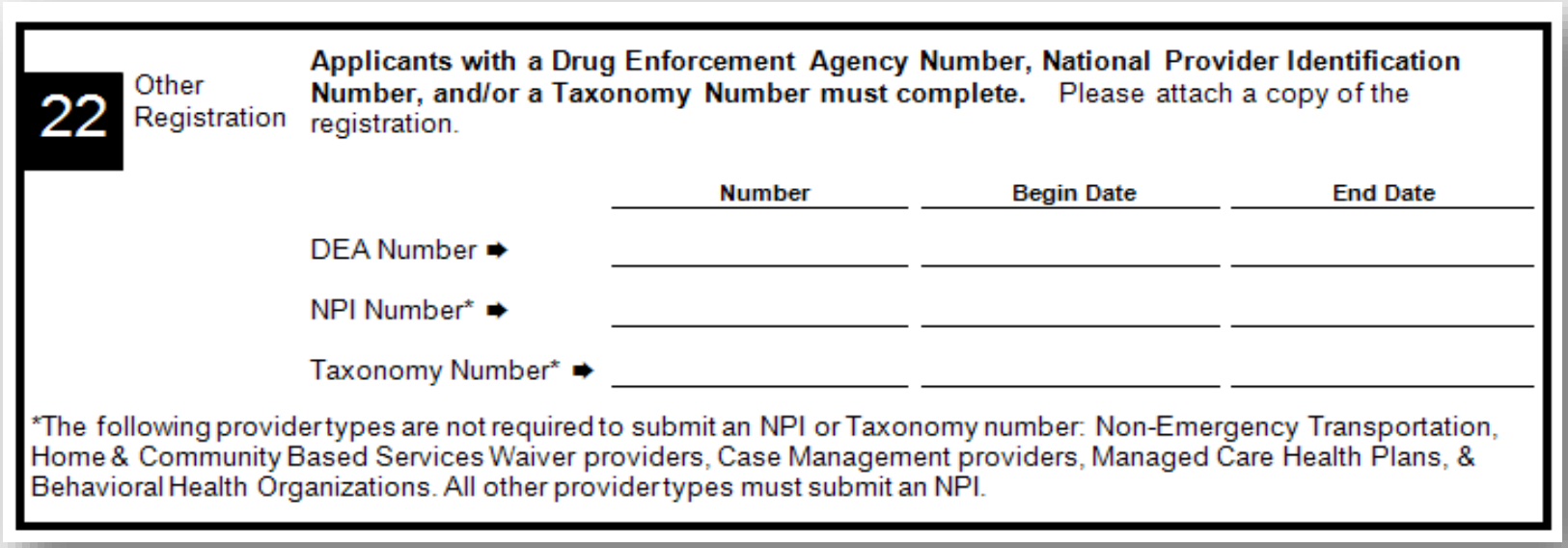
Hospital and Nursing Facility applicants must complete.

Hospitals ➡	Number of Inpatient beds	_____
Nursing Facilities ➡	Number of Skilled Beds	_____
	Number of ICF Beds	_____
ACF ➡	Number of ACF Beds	_____

Registration Information

Section 22 – Other Registration Information

- DEA Number – Required to stock or distribute controlled substances
- NPI Number – National Provider Identifier (NPI)
- Taxonomy Number – hierarchical code set designed to categorize the type, classification, and/or specialization of health care providers



22 Other Registration

Applicants with a Drug Enforcement Agency Number, National Provider Identification Number, and/or a Taxonomy Number must complete. Please attach a copy of the registration.

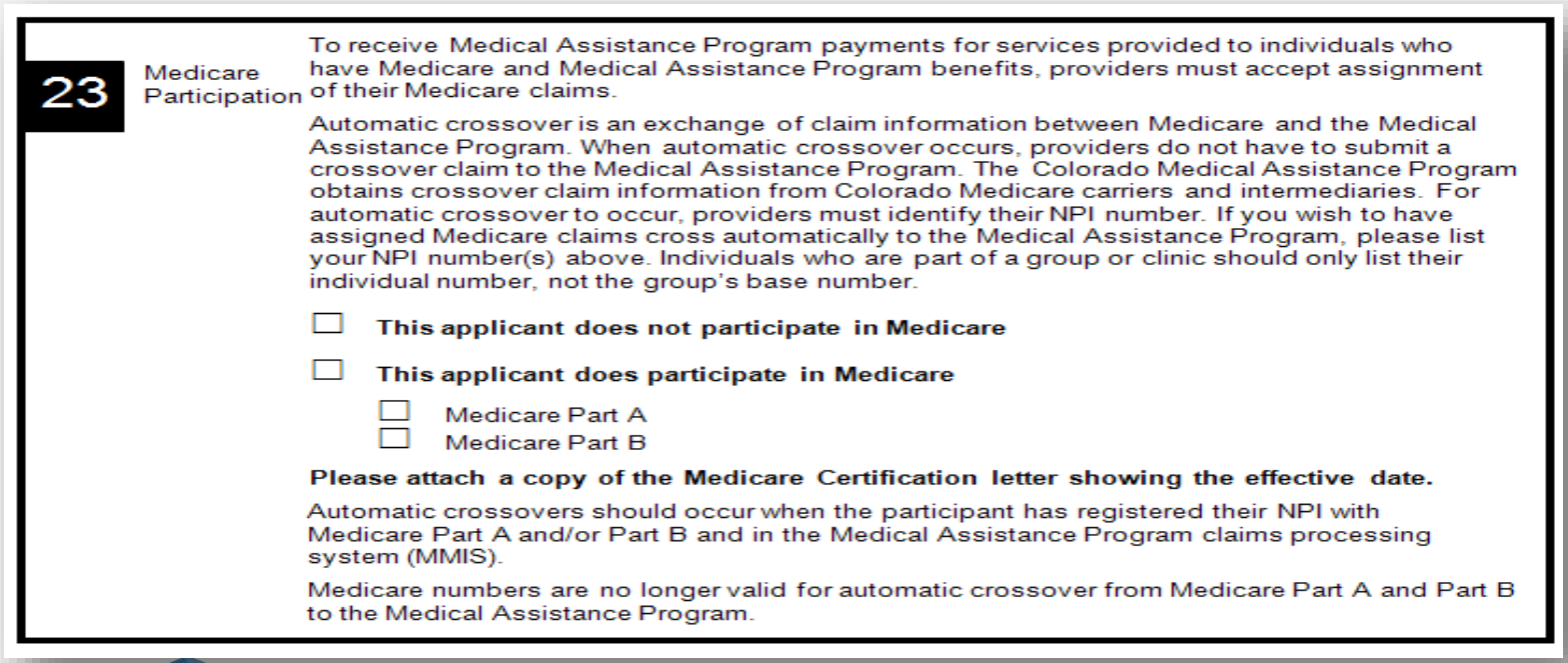
	Number	Begin Date	End Date
DEA Number ➡			
NPI Number* ➡			
Taxonomy Number* ➡			

*The following provider types are not required to submit an NPI or Taxonomy number: Non-Emergency Transportation, Home & Community Based Services Waiver providers, Case Management providers, Managed Care Health Plans, & Behavioral Health Organizations. All other provider types must submit an NPI.

Registration Information

Section 23 – Medicare Participation Information

- Check the appropriate participation box
- If yes, also check Medicare A and/or Medicare B box
- Copy of certification must be submitted showing effective date



23 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. If you wish to have assigned Medicare claims cross automatically to the Medical Assistance Program, please list your NPI number(s) above. Individuals who are part of a group or clinic should only list their individual number, not the group's base number.

☐ **This applicant does not participate in Medicare**

☐ **This applicant does participate in Medicare**

- ☐ Medicare Part A
- ☐ Medicare Part B

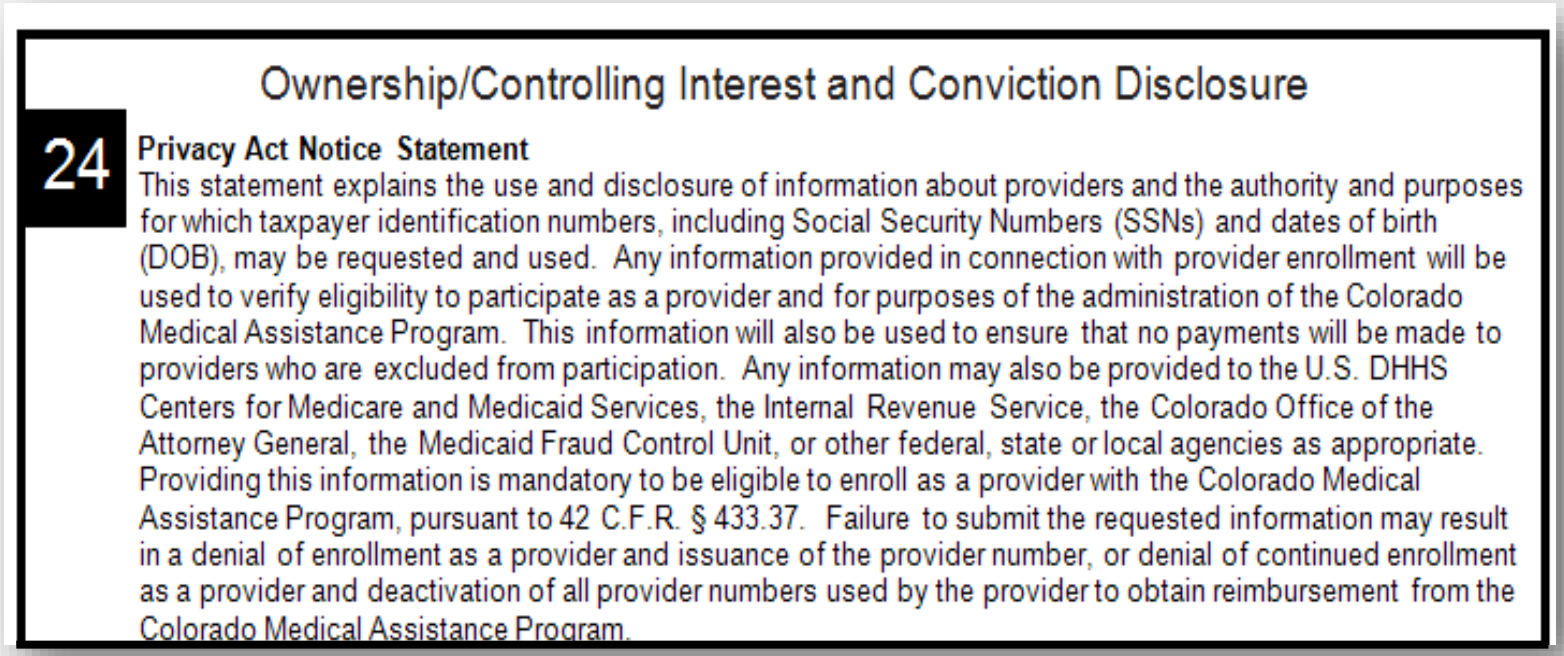
Please attach a copy of the Medicare Certification letter showing the effective date.

Automatic crossovers should occur when the participant has registered their NPI with Medicare Part A and/or Part B and in the Medical Assistance Program claims processing system (MMIS).

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

Provider Disclosures

- All applicants must complete each field A through F



Ownership/Controlling Interest and Conviction Disclosure

24 **Privacy Act Notice Statement**

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 and issuance of the provider number, 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.

Provider Disclosures

- Check the appropriate entity type
- Enter ownership or controlling interest in enrolling entity in Field A

Entity completing document is:

☐ Provider ☐ Disclosing entity ☐ Other Disclosing entity ☐ Fiscal Agent ☐ Managed care entity

A. List the 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 having direct or indirect ownership of 5% or more. Corporate entities must list, as applicable, primary business address, every business location, and P.O. Box address. *If more space is needed attach a separate list including the required information.*

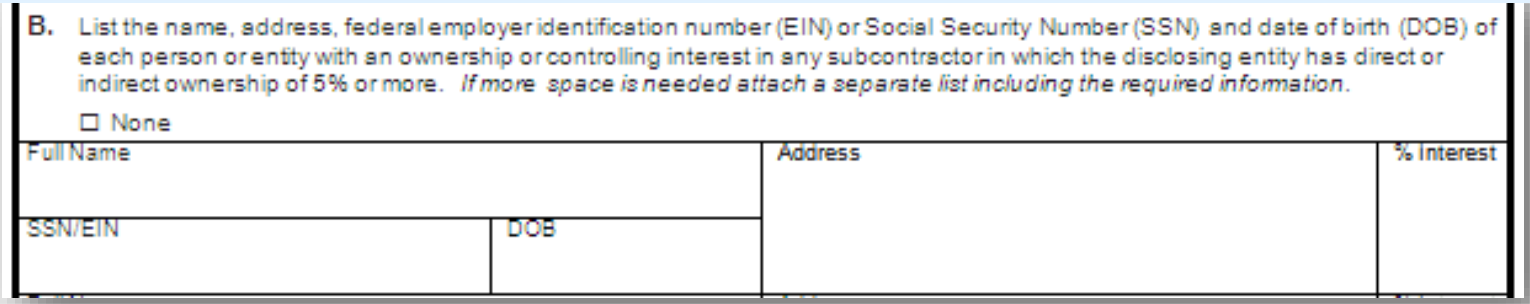
☐ I am an individual using my SSN for enrollment and ownership/control interest does not apply.

Full Name		Address	% Interest
SSN/EIN	DOB		

Provider Disclosures

Field B –

- Enter ownership or controlling interest, of subcontractor(s) the enrolling entity has ownership of



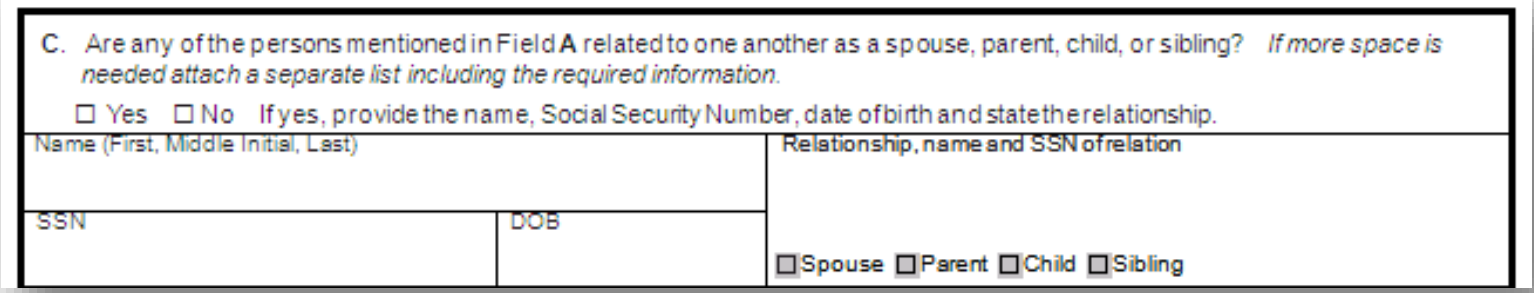
B. List the name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person or entity with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. *If more space is needed attach a separate list including the required information.*

☐ None

Full Name		Address	% Interest
SSN/EIN	DOB		

Field C –

- Enter relationships regarding names entered in Field A



C. Are any of the persons mentioned in Field A related to one another as a spouse, parent, child, or sibling? *If more space is needed attach a separate list including the required information.*

☐ Yes ☐ No If yes, provide the name, Social Security Number, date of birth and state the relationship.

Name (First, Middle Initial, Last)		Relationship, name and SSN of relation
SSN	DOB	☐ Spouse ☐ Parent ☐ Child ☐ Sibling

Provider Disclosures

Field D –

- List all managing employees of the enrolling entity

D. List any person who holds a position of managing employee within the disclosing entity, fiscal agent or managed care entity. *If more space is needed attach a separate sheet with the required information.*

☐ None

Name (First, Middle Initial, Last)		Address
SSN	DOB	

Field E –

- Regarding names entered in Field A, list ownership in any other provider

E. Does any person, business, organization or corporation with an ownership or control interest (identified in Field **A**) have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity? *If more space is needed attach a separate sheet with the required information.*

☐ No

Full Name		Other Provider Name and SSN/EIN	% Interest
SSN/EIN	DOB		

Provider Disclosures

Field F –

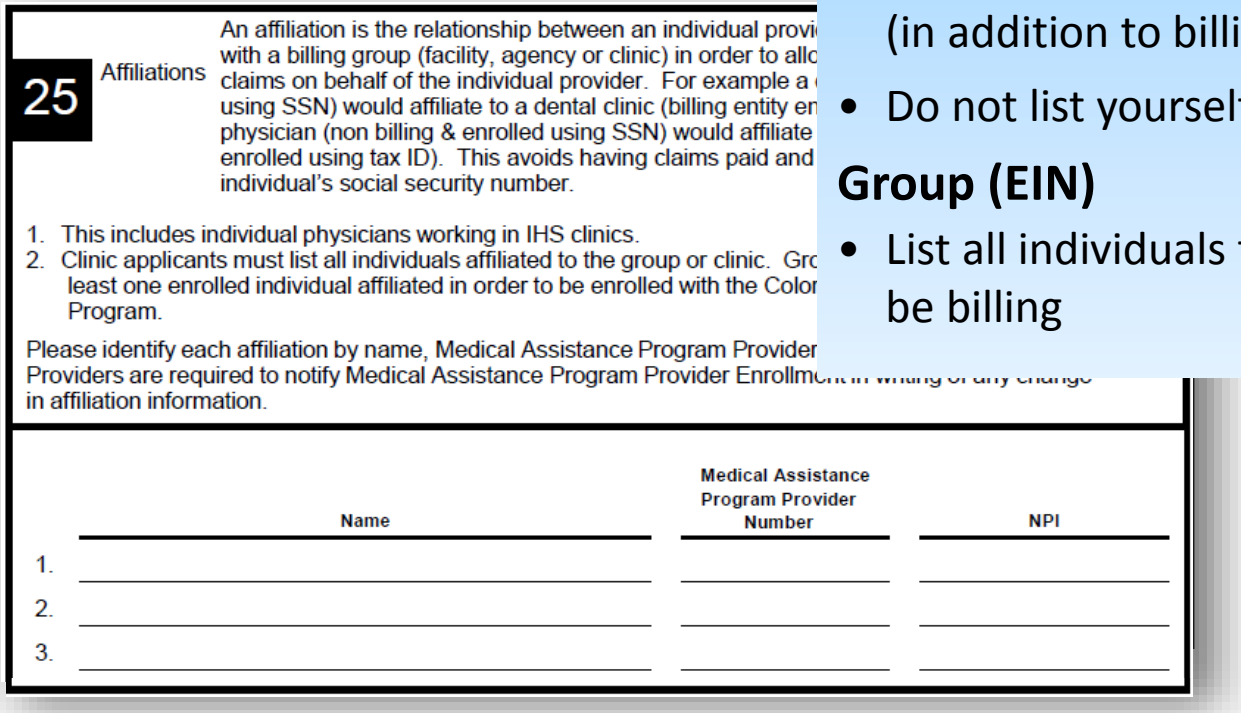
- List criminal convictions involving any program under Medicare, Medicaid, Children's Health Insurance Program, Title XX

F. List any person 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 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. *If more space is needed attach a separate sheet with the required information.*

☐ None

Full Name		Conviction Date, Offense and Jurisdiction
SSN/EIN	DOB	

Affiliation Information



25 Affiliations

An affiliation is the relationship between an individual provi
with a billing group (facility, agency or clinic) in order to allo
claims on behalf of the individual provider. For example a
using SSN) would affiliate to a dental clinic (billing entity en
physician (non billing & enrolled using SSN) would affiliate
enrolled using tax ID). This avoids having claims paid and
individual's social security number.

1. This includes individual physicians working in IHS clinics.
2. Clinic applicants must list all individuals affiliated to the group or clinic. Gro
least one enrolled individual affiliated in order to be enrolled with the Color
Program.

Please identify each affiliation by name, Medical Assistance Program Provider
Providers are required to notify Medical Assistance Program Provider Enrollm
in affiliation information.

	Name	Medical Assistance Program Provider Number	NPI
1.			
2.			
3.			

Individual (SSN)

- List any groups that may bill for you (in addition to billing for yourself)
- Do not list yourself

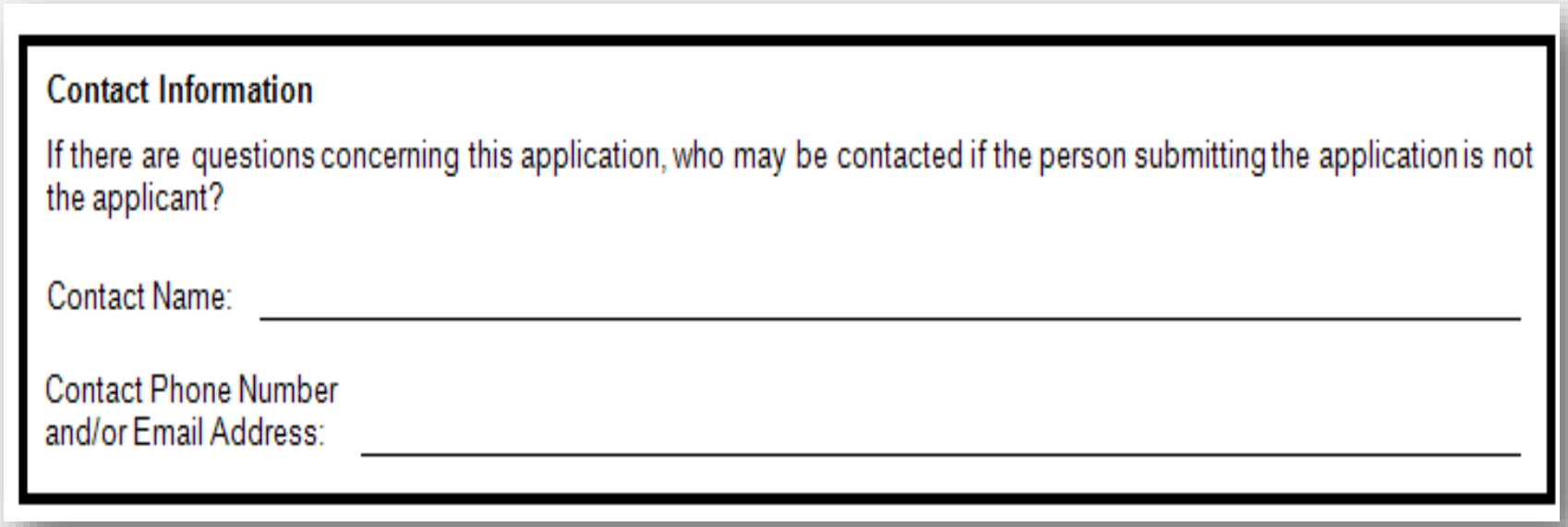
Group (EIN)

- List all individuals for whom you will be billing

Contact Information

Contact Information

- If person submitting application is not the applicant, complete requested information



Contact Information

If there are questions concerning this application, who may be contacted if the person submitting the application is not the applicant?

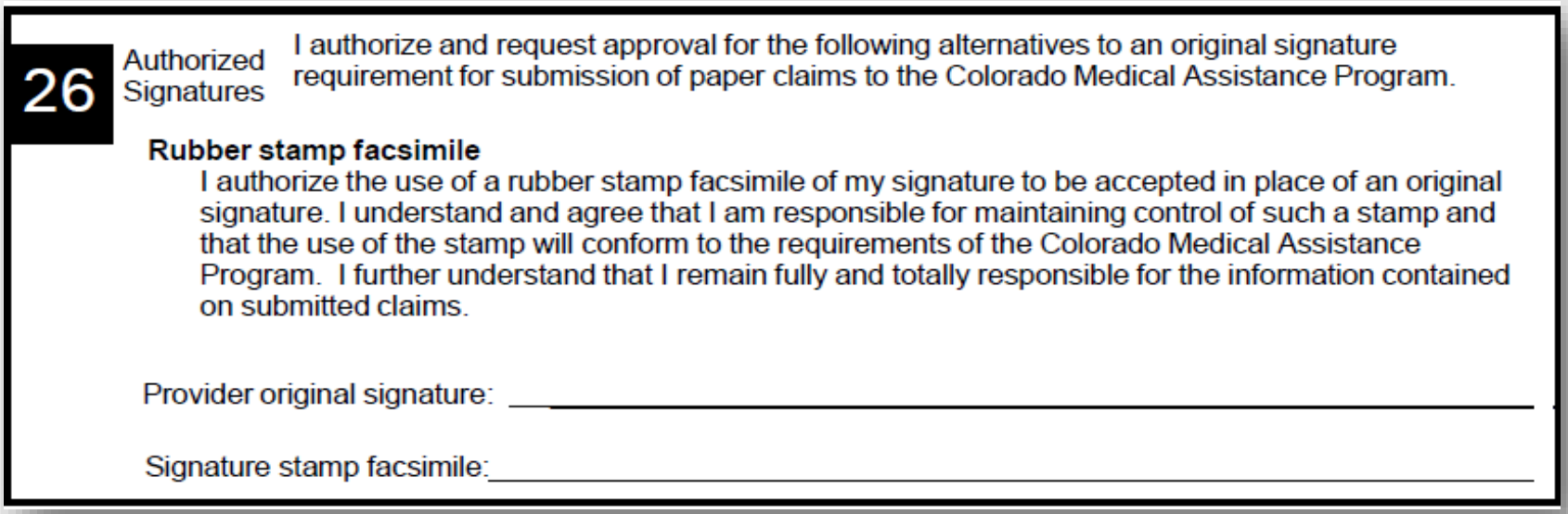
Contact Name: _____

Contact Phone Number and/or Email Address: _____

Signature Authorizations

Rubber stamp facsimile

- If applicant authorizes use of rubber stamp:
  - **Original** signature required on **line one**
  - **Stamp** signature impression on **line two**



26 Authorized Signatures

I authorize and request approval for the following alternatives to an original signature requirement for submission of paper claims to the Colorado Medical Assistance Program.

Rubber stamp facsimile

I authorize the use of a rubber stamp facsimile of my signature to be accepted in place of an original signature. I understand and agree that I am responsible for maintaining control of such a stamp and that the use of the stamp will conform to the requirements of the Colorado Medical Assistance Program. I further understand that I remain fully and totally responsible for the information contained on submitted claims.

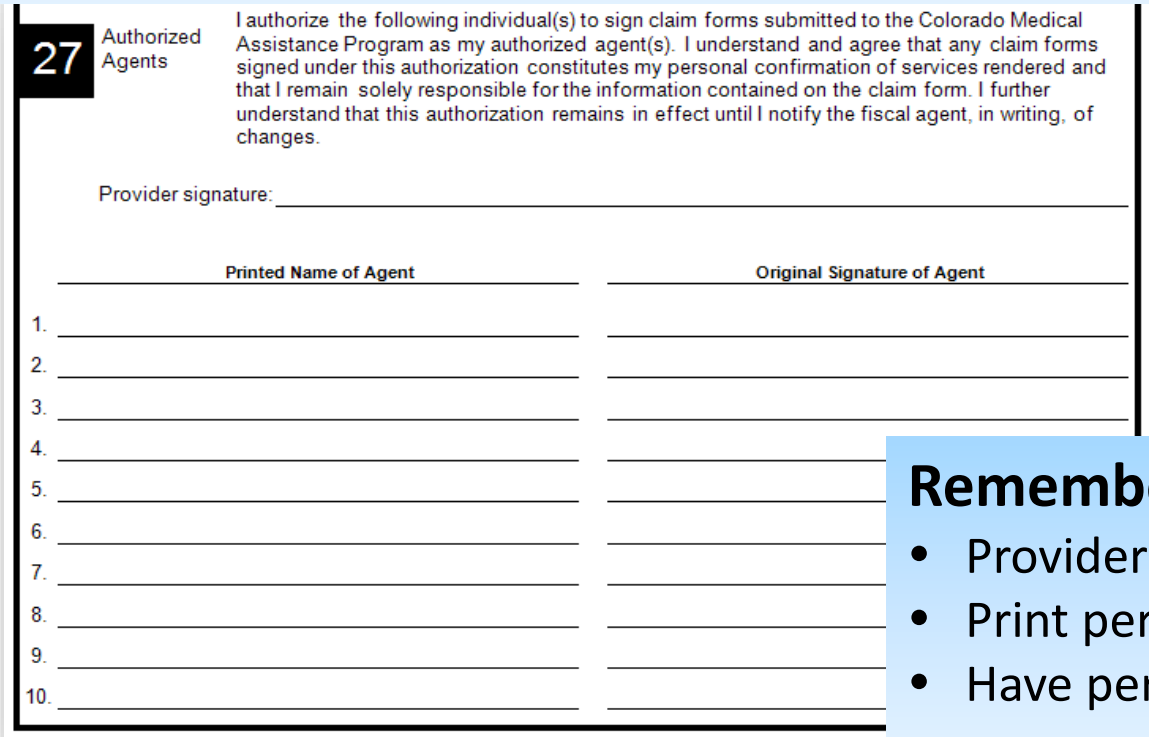
Provider original signature: _____

Signature stamp facsimile: _____

Signature Authorizations

Authorized Agents

- If applicant authorizes others to take responsibilities for Colorado Medical Assistance Program billing or reports



27 Authorized Agents

I authorize the following individual(s) to sign claim forms submitted to the Colorado Medical Assistance Program as my authorized agent(s). I understand and agree that any claim forms signed under this authorization constitutes my personal confirmation of services rendered and that I remain solely responsible for the information contained on the claim form. I further understand that this authorization remains in effect until I notify the fiscal agent, in writing, of changes.

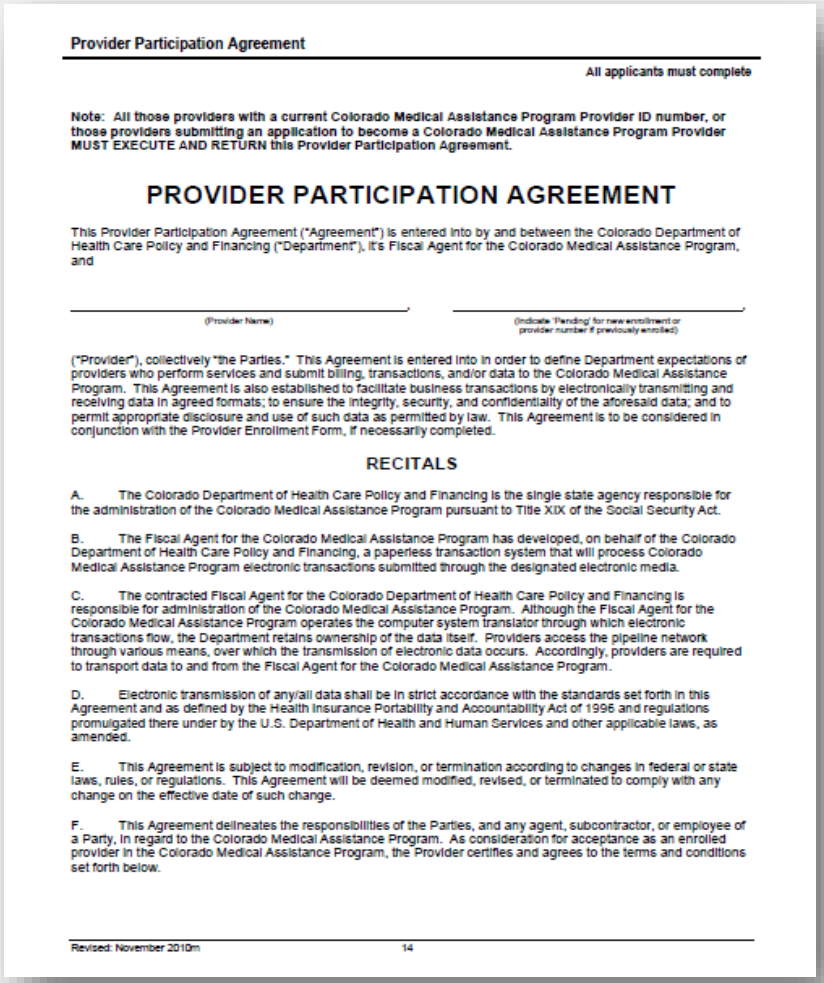
Provider signature: _____

	Printed Name of Agent	Original Signature of Agent
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Remember:

- Provider signature required
- Print person(s) name
- Have person(s) sign

Provider Participation Agreement



Provider Participation Agreement

All applicants must complete

Note: All those providers with a current Colorado Medical Assistance Program Provider ID number, or those providers submitting an application to become a Colorado Medical Assistance Program Provider MUST EXECUTE AND RETURN this Provider Participation Agreement.

PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement ("Agreement") is entered into by and between the Colorado Department of Health Care Policy and Financing ("Department"), it's Fiscal Agent for the Colorado Medical Assistance Program, and

_____, _____,
(Provider Name) (Indicate 'Pending' for new enrollment or provider number if previously enrolled)

("Provider"), collectively "the Parties." This Agreement is entered into in order to define Department expectations of providers who perform services and submit billing, transactions, and/or data to the Colorado Medical Assistance Program. This Agreement is also established to facilitate business transactions by electronically transmitting and receiving data in agreed formats; to ensure the integrity, security, and confidentiality of the aforesaid data; and to permit appropriate disclosure and use of such data as permitted by law. This Agreement is to be considered in conjunction with the Provider Enrollment Form, if necessarily completed.

RECITALS

A. The Colorado Department of Health Care Policy and Financing is the single state agency responsible for the administration of the Colorado Medical Assistance Program pursuant to Title XIX of the Social Security Act.

B. The Fiscal Agent for the Colorado Medical Assistance Program has developed, on behalf of the Colorado Department of Health Care Policy and Financing, a paperless transaction system that will process Colorado Medical Assistance Program electronic transactions submitted through the designated electronic media.

C. The contracted Fiscal Agent for the Colorado Department of Health Care Policy and Financing is responsible for administration of the Colorado Medical Assistance Program. Although the Fiscal Agent for the Colorado Medical Assistance Program operates the computer system translator through which electronic transactions flow, the Department retains ownership of the data itself. Providers access the pipeline network through various means, over which the transmission of electronic data occurs. Accordingly, providers are required to transport data to and from the Fiscal Agent for the Colorado Medical Assistance Program.

D. Electronic transmission of any/all data shall be in strict accordance with the standards set forth in this Agreement and as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under by the U.S. Department of Health and Human Services and other applicable laws, as amended.

E. This Agreement is subject to modification, revision, or termination according to changes in federal or state laws, rules, or regulations. This Agreement will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

F. This Agreement delineates the responsibilities of the Parties, and any agent, subcontractor, or employee of a Party, in regard to the Colorado Medical Assistance Program. As consideration for acceptance as an enrolled provider in the Colorado Medical Assistance Program, the Provider certifies and agrees to the terms and conditions set forth below.

Revised: November 2010m 14

Review these pages

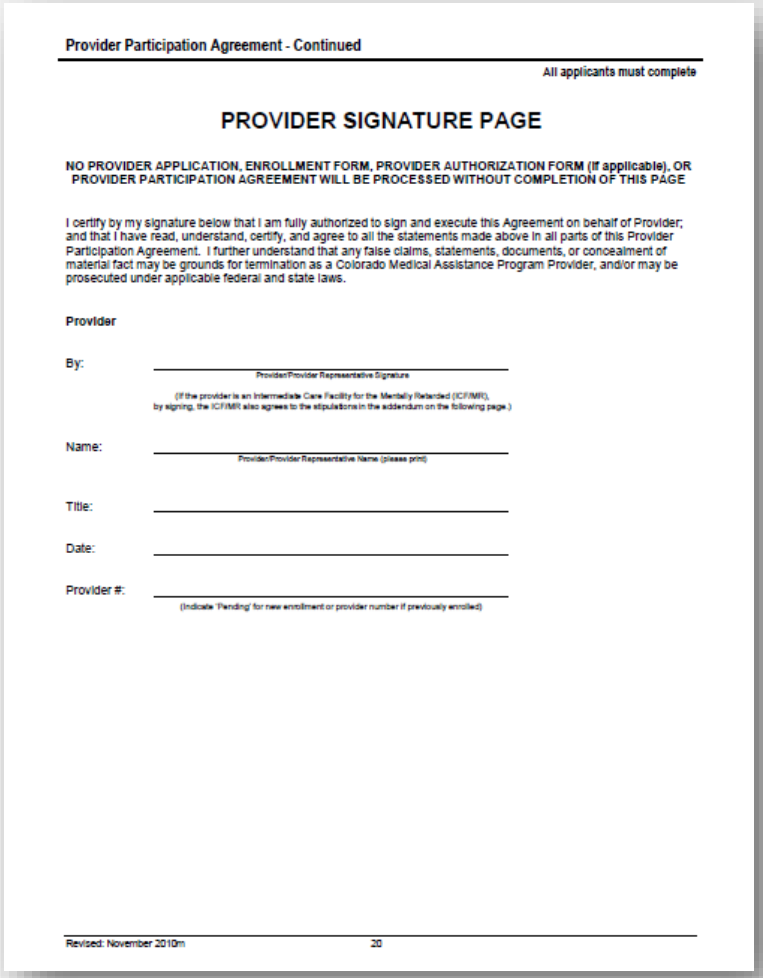
Individual (SSN)

- Print individual's name & "pending" for new enrollment

Group (EIN)

- Print legal name & "pending" for new enrollment

Provider Signature Page



Provider Participation Agreement - Continued

All applicants must complete

PROVIDER SIGNATURE PAGE

NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (If applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE

I certify by my signature below that I am fully authorized to sign and execute this Agreement on behalf of Provider; and that I have read, understand, certify, and agree to all the statements made above in all parts of this Provider Participation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a Colorado Medical Assistance Program Provider, and/or may be prosecuted under applicable federal and state laws.

Provider

By: _____
Provider/Provider Representative Signature

(If the provider is an Intermediate Care Facility for the Mentally Retarded (ICF/MR), by signing, the ICF/MR also agrees to the stipulations in the addendum on the following page.)

Name: _____
Provider/Provider Representative Name (please print)

Title: _____

Date: _____

Provider #: _____
(Indicate 'Pending' for new enrollment or provider number if previously enrolled)

Revised: November 2010m 20

Individual (SSN) applicant

- Individual must sign

Group (EIN) applicant

- Authorized person must sign

Provider

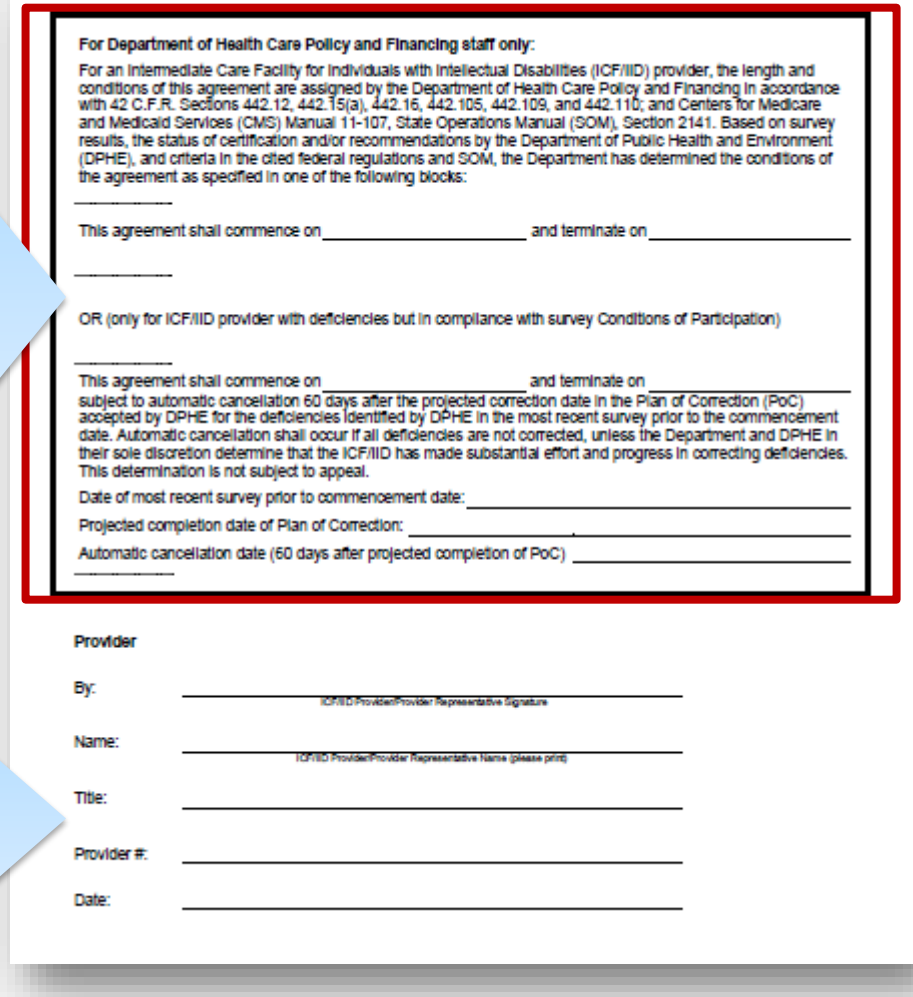
- Indicate “pending” for new enrollment or
- Write provider number if previously enrolled

Provider Signature Page for ICF/IID Only

For **Intermediate Care Facility** for Individuals with Intellectual Disabilities (ICF/IID) **Only**

To be completed by Department of Health Care Policy & Financing staff

Complete signature portion if you are enrolling as an ICF/IID



For Department of Health Care Policy and Financing staff only:

For an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) provider, the length and conditions of this agreement are assigned by the Department of Health Care Policy and Financing in accordance with 42 C.F.R. Sections 442.12, 442.15(a), 442.16, 442.105, 442.109, and 442.110; and Centers for Medicare and Medicaid Services (CMS) Manual 11-107, State Operations Manual (SOM), Section 2141. Based on survey results, the status of certification and/or recommendations by the Department of Public Health and Environment (DPHE), and criteria in the cited federal regulations and SOM, the Department has determined the conditions of the agreement as specified in one of the following blocks:

_____

This agreement shall commence on _____ and terminate on _____

_____

OR (only for ICF/IID provider with deficiencies but in compliance with survey Conditions of Participation)

_____

This agreement shall commence on _____ and terminate on _____ subject to automatic cancellation 60 days after the projected correction date in the Plan of Correction (PoC) accepted by DPHE for the deficiencies identified by DPHE in the most recent survey prior to the commencement date. Automatic cancellation shall occur if all deficiencies are not corrected, unless the Department and DPHE in their sole discretion determine that the ICF/IID has made substantial effort and progress in correcting deficiencies. This determination is not subject to appeal.

Date of most recent survey prior to commencement date: _____

Projected completion date of Plan of Correction: _____

Automatic cancellation date (60 days after projected completion of PoC) _____

_____

Provider

By: _____
ICF/IID Provider/Provider Representative Signature

Name: _____
ICF/IID Provider/Provider Representative Name (please print)

Title: _____

Provider #: _____

Date: _____

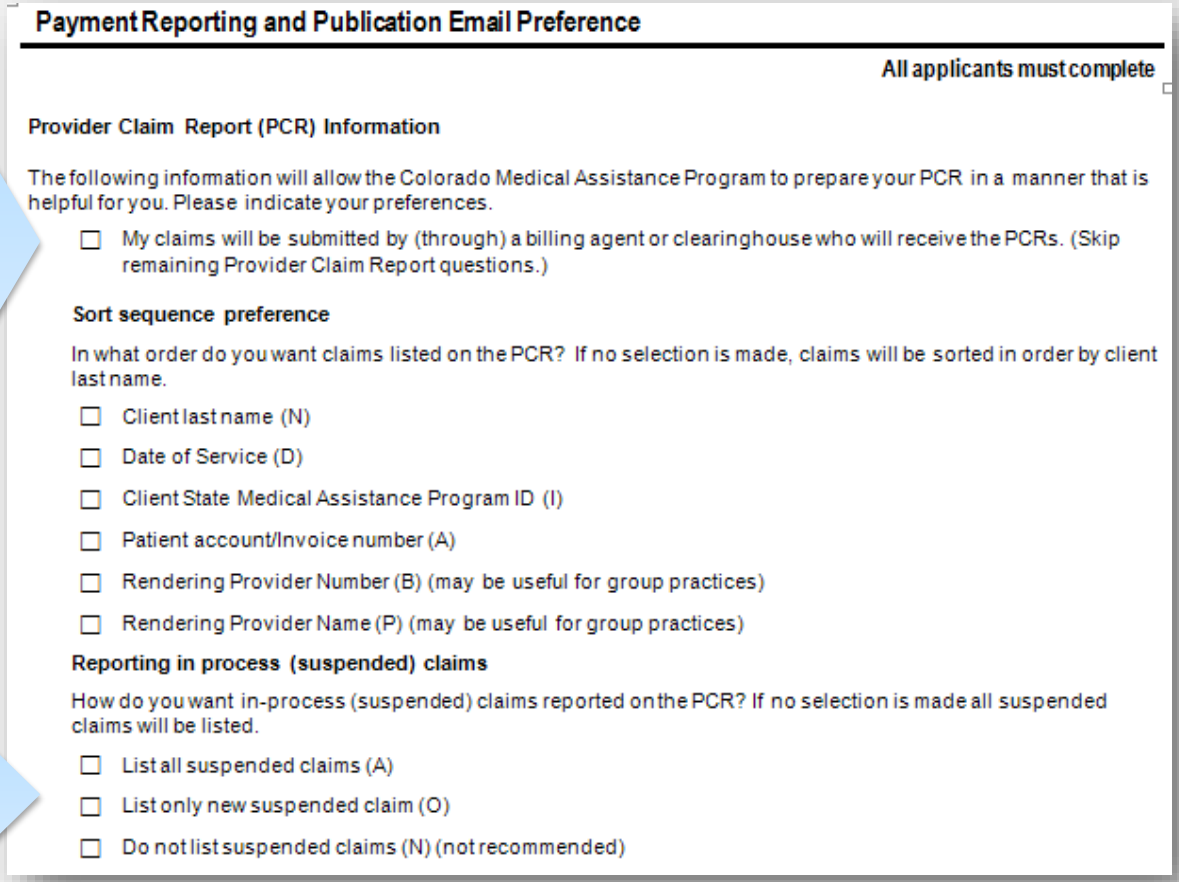
Payment Reporting & Publication Preferences

If using billing agent or clearinghouse to receive PCR's:

- check this box
- skip to Publication Email Notification Preference section

If no selection is made:

- claims will be sorted by member last name
- all suspended claims will be listed



Payment Reporting and Publication Email Preference

All applicants must complete

Provider Claim Report (PCR) Information

The following information will allow the Colorado Medical Assistance Program to prepare your PCR in a manner that is helpful for you. Please indicate your preferences.

☐ My claims will be submitted by (through) a billing agent or clearinghouse who will receive the PCRs. (Skip remaining Provider Claim Report questions.)

Sort sequence preference

In what order do you want claims listed on the PCR? If no selection is made, claims will be sorted in order by client last name.

☐ Client last name (N)

☐ Date of Service (D)

☐ Client State Medical Assistance Program ID (I)

☐ Patient account/Invoice number (A)

☐ Rendering Provider Number (B) (may be useful for group practices)

☐ Rendering Provider Name (P) (may be useful for group practices)

Reporting in process (suspended) claims

How do you want in-process (suspended) claims reported on the PCR? If no selection is made all suspended claims will be listed.

☐ List all suspended claims (A)

☐ List only new suspended claim (O)

☐ Do not list suspended claims (N) (not recommended)

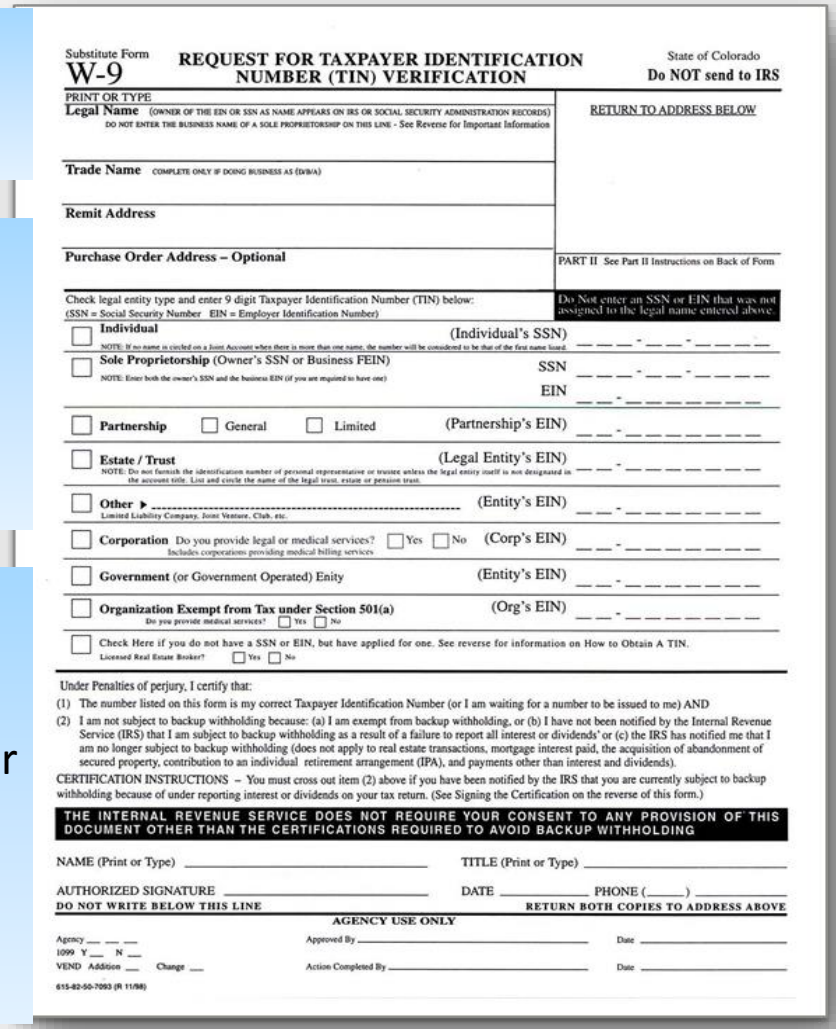
Appendix A

Reference Information for Services Identification

- Lists provider type requirements
- Use to determine if license or certification is required
- Submit copy of license showing begin & expiration dates
  - If license does not have a begin date and/or expiration date, obtain document with these dates from licensing entity

W-9

- **Individual (SSN) applicants must complete using SSN**
- **Business (EIN) – Enter legal name exactly as registered with IRS**
  - Do not enter legal name on Trade Name (Doing Business As) line
- **Individual applicants who have an EIN must:**
  - Enroll as an individual provider type under their SSN
  - Submit separate application for group provider type under EIN



Substitute Form W-9 — REQUEST FOR TAXPAYER IDENTIFICATION NUMBER (TIN) VERIFICATION — State of Colorado: Do NOT send to IRS

PRINT OR TYPE

Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON IRS OR SOCIAL SECURITY ADMINISTRATION RECORDS) DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPRIETORSHIP ON THIS LINE - See Reverse for Important Information

Trade Name COMPLETE ONLY IF DOING BUSINESS AS (D/B/A)

Remit Address

Purchase Order Address – Optional

RETURN TO ADDRESS BELOW

PART II See Part II Instructions on Back of Form

Check legal entity type and enter 9 digit Taxpayer Identification Number (TIN) below: (SSN = Social Security Number EIN = Employer Identification Number)

Do Not enter an SSN or EIN that was not assigned to the legal name entered above.

- ☐ Individual (Individual's SSN) ___-___-____
- ☐ Sole Proprietorship (Owner's SSN or Business FEIN) SSN ___-___-____ EIN ___-_______
- ☐ Partnership ☐ General ☐ Limited (Partnership's EIN) ___-_______
- ☐ Estate / Trust (Legal Entity's EIN) ___-_______
- ☐ Other ▶ (Entity's EIN) ___-_______
- ☐ Corporation Do you provide legal or medical services? ☐ Yes ☐ No (Corp's EIN) ___-_______
- ☐ Government (or Government Operated) Enity (Entity's EIN) ___-_______
- ☐ Organization Exempt from Tax under Section 501(a) Do you provide medical services? ☐ Yes ☐ No (Org's EIN) ___-_______
- ☐ Check Here if you do not have a SSN or EIN, but have applied for one. See reverse for information on How to Obtain A TIN. Licensed Real Estate Broker? ☐ Yes ☐ No

Under Penalties of perjury, I certify that:

(1) The number listed on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me) AND

(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends' or (c) the IRS has notified me that I am no longer subject to backup withholding (does not apply to real estate transactions, mortgage interest paid, the acquisition of abandonment of secured property, contribution to an individual retirement arrangement (IPA), and payments other than interest and dividends).

CERTIFICATION INSTRUCTIONS – You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return. (See Signing the Certification on the reverse of this form.)

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATIONS REQUIRED TO AVOID BACKUP WITHHOLDING

NAME (Print or Type) _____ TITLE (Print or Type) _____

AUTHORIZED SIGNATURE _____ DATE _____ PHONE (____) _____

DO NOT WRITE BELOW THIS LINE — RETURN BOTH COPIES TO ADDRESS ABOVE

AGENCY USE ONLY

Agency ___ ___ ___ 1099 Y___ N___ VEND Addition___ Change___

Approved By _____ Date _____

Action Completed By _____ Date _____

615-82-50-7093 (R 11/98)

Authorization Agreement for Automatic Deposits (EFT)

- **State requires EFT for:**
  - All in-state and border groups, clinics and facilities
  - Individual providers seeking direct reimbursement

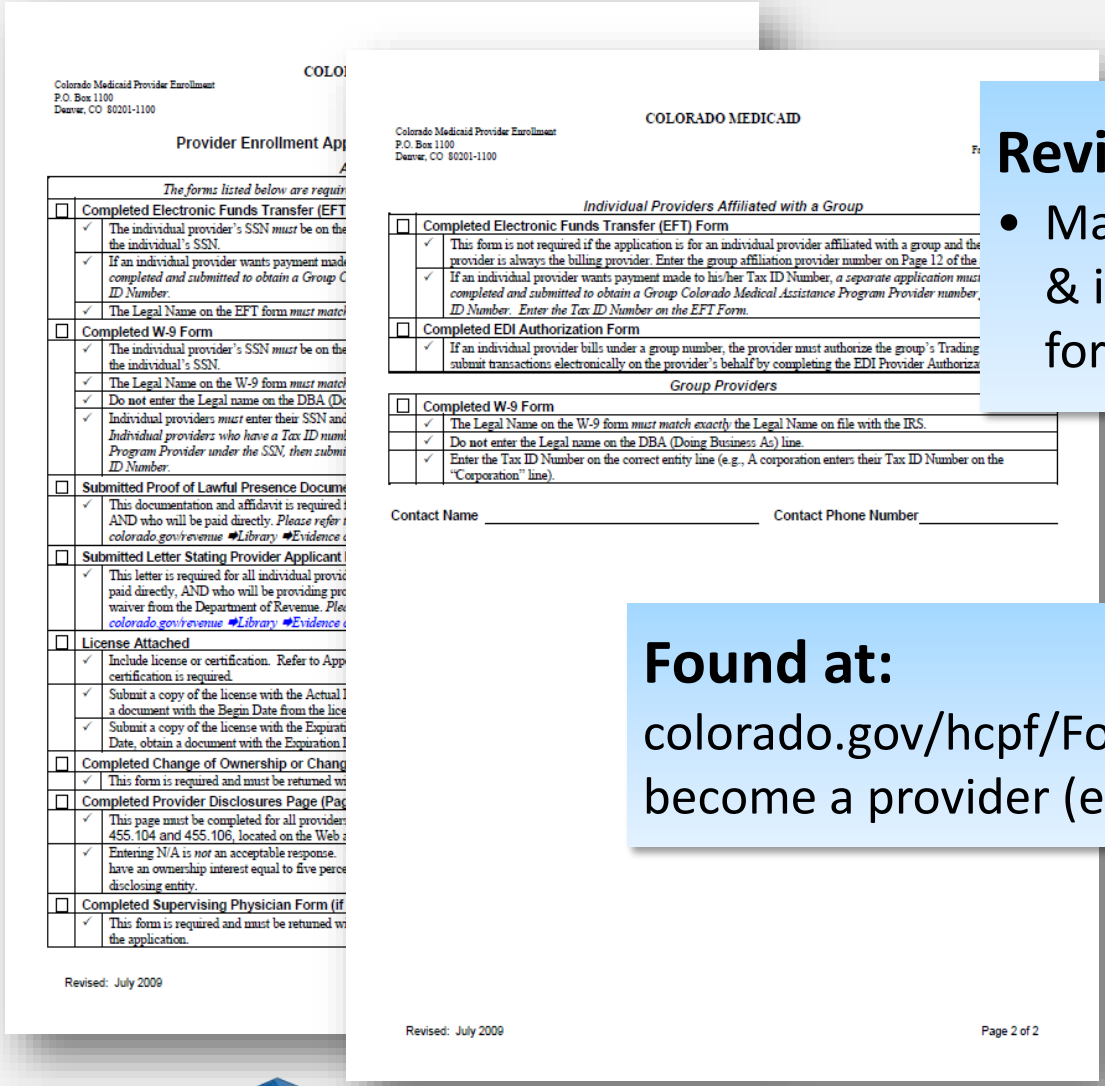
- Individuals enrolling for direct reimbursement must complete using SSN
- Groups must enter legal name & EIN exactly as registered with IRS

Authorization Agreement for Automatic Deposits (EFT)

- **Remember to submit either:**
  - Preprinted voided check or bank letter for checking account deposits
  - Bank letter for savings account deposits

- Bank letters must be dated **within the last 6** months
- Temporary checks are **not** acceptable

Provider Enrollment Checklist



Colorado Medicaid Provider Enrollment
P.O. Box 1100
Denver, CO 80201-1100

Provider Enrollment App

The forms listed below are requir

- ☐ Completed Electronic Funds Transfer (EFT
  - ✓ The individual provider's SSN *must* be on the the individual's SSN.
  - ✓ If an individual provider wants payment made *completed and submitted to obtain a Group C ID Number.*
  - ✓ The Legal Name on the EFT form *must matc*
- ☐ Completed W-9 Form
  - ✓ The individual provider's SSN *must* be on the the individual's SSN.
  - ✓ The Legal Name on the W-9 form *must match*
  - ✓ Do not enter the Legal name on the DBA (Do
  - ✓ Individual providers *must* enter their SSN and *Individual providers who have a Tax ID numb Program Provider under the SSN, then submi ID Number.*
- ☐ Submitted Proof of Lawful Presence Docume
  - ✓ This documentation and affidavit is required AND who will be paid directly. *Please refer colorado.gov/revenue ➡Library ➡Evidence*
- ☐ Submitted Letter Stating Provider Applicant
  - ✓ This letter is required for all individual provic paid directly, AND who will be providing pro waiver from the Department of Revenue. *Ple colorado.gov/revenue ➡Library ➡Evidence*
- ☐ License Attached
  - ✓ Include license or certification. Refer to App certification is required.
  - ✓ Submit a copy of the license with the Actual I a document with the Begin Date from the lice
  - ✓ Submit a copy of the license with the Expirati Date, obtain a document with the Expiration I
- ☐ Completed Change of Ownership or Chang
  - ✓ This form is required and must be returned wi
- ☐ Completed Provider Disclosures Page (Pag
  - ✓ This page must be completed for all providers 455.104 and 455.106, located on the Web
  - ✓ Entering N/A is *not* an acceptable response. have an ownership interest equal to five perce disclosing entity.
- ☐ Completed Supervising Physician Form (if
  - ✓ This form is required and must be returned wi the application.

Revised: July 2009

COLORADO MEDICAID

Colorado Medicaid Provider Enrollment
P.O. Box 1100
Denver, CO 80201-1100

Individual Providers Affiliated with a Group

- ☐ Completed Electronic Funds Transfer (EFT) Form
  - ✓ This form is not required if the application is for an individual provider affiliated with a group and the provider is always the billing provider. Enter the group affiliation provider number on Page 12 of the
  - ✓ If an individual provider wants payment made to his/her Tax ID Number, *a separate application must completed and submitted to obtain a Group Colorado Medical Assistance Program Provider number ID Number. Enter the Tax ID Number on the EFT Form.*
- ☐ Completed EDI Authorization Form
  - ✓ If an individual provider bills under a group number, the provider must authorize the group's Trading submit transactions electronically on the provider's behalf by completing the EDI Provider Authoriza

Group Providers

- ☐ Completed W-9 Form
  - ✓ The Legal Name on the W-9 form *must match exactly* the Legal Name on file with the IRS.
  - ✓ Do not enter the Legal name on the DBA (Doing Business As) line.
  - ✓ Enter the Tax ID Number on the correct entity line (e.g., A corporation enters their Tax ID Number on the "Corporation" line).

Contact Name _____ Contact Phone Number _____

Revised: July 2009 Page 2 of 2

Review checklist carefully

- Make sure that you complete & include everything required for your provider type

Found at:

colorado.gov/hcpf/For Our Providers/How to become a provider (enroll)

Submission Address

Please return the completed application to the following address:

Colorado Medical Assistance Program
Provider Services
P.O. Box 1100
Denver, CO 80201-1100

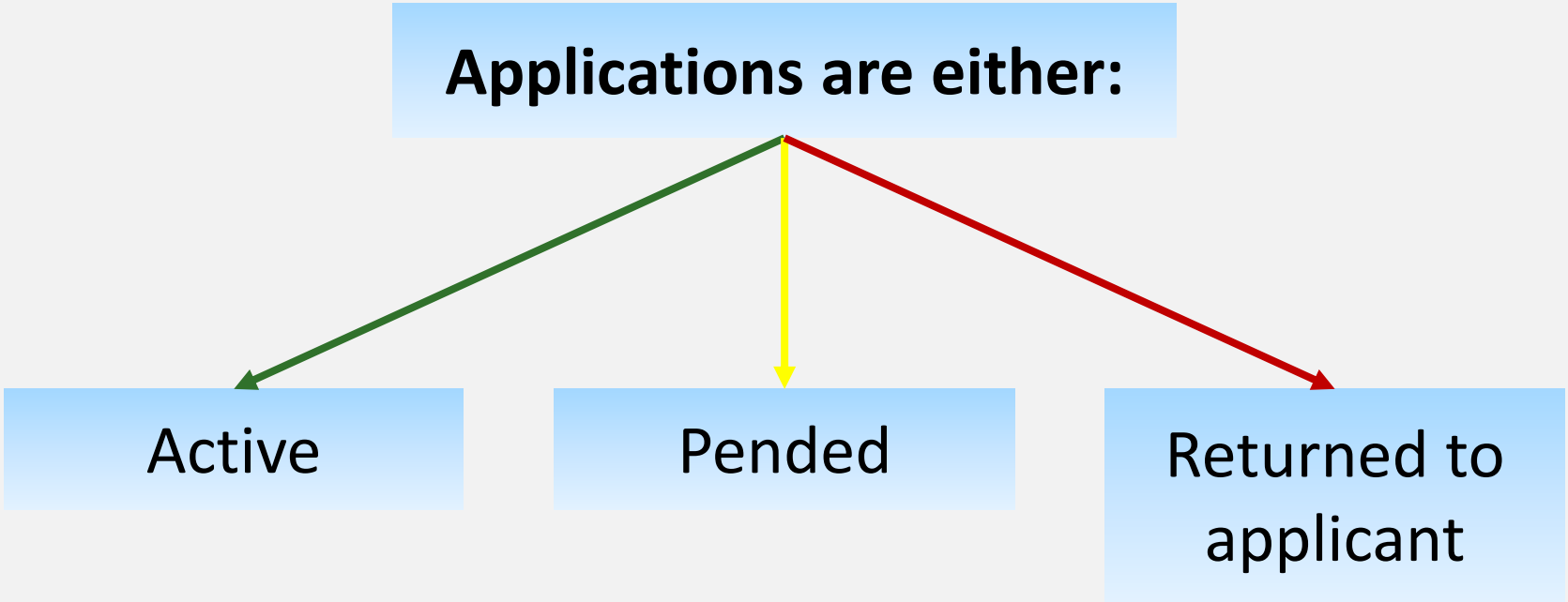
Thank you for your interest and submitting an enrollment application.

Please return completed Provider Enrollment Application to address shown

Make and retain a copy of the completed application for your records

Application Processing Timeline

Applications are processed within eight business days from date of receipt at the fiscal agent office



Pending Enrollment

If application is pending:

- notification letter is sent to applicant with instructions

Replacement documents must:

- be received within 60 days
- include pending letter or control number noted on each document

Failure to do so will result in a denied application:

- a new application will be required

Approved Enrollment

Provider receives approval letter & Turn-Around Document (TAD) within two weeks indicating acceptance:

Provider must review TAD for accuracy

If TAD has no errors:

- no further action is needed

If any errors are found:

- make necessary corrections
- mail to Provider Enrollment
- changes will be made within five business days of receipt

Approval Letter

Dear Provider,

Your request for participation in the Colorado Medicaid Program has been approved.
Your Colorado Medicaid provider number is
Your NPI number(s) are as follows:

You must use your NPI(s) after 06/23/2007 when submitting claims or communicating with the Medicaid Program.
You have been approved to submit claims for the services noted below provided on and after .

Service(s)	Claim type(s)

Please read the enclosed information carefully. We suggest that you read the provider participation section of the provider manual as soon as possible. Instructions for submitting claims and ordering claim forms are included in the provider manual.

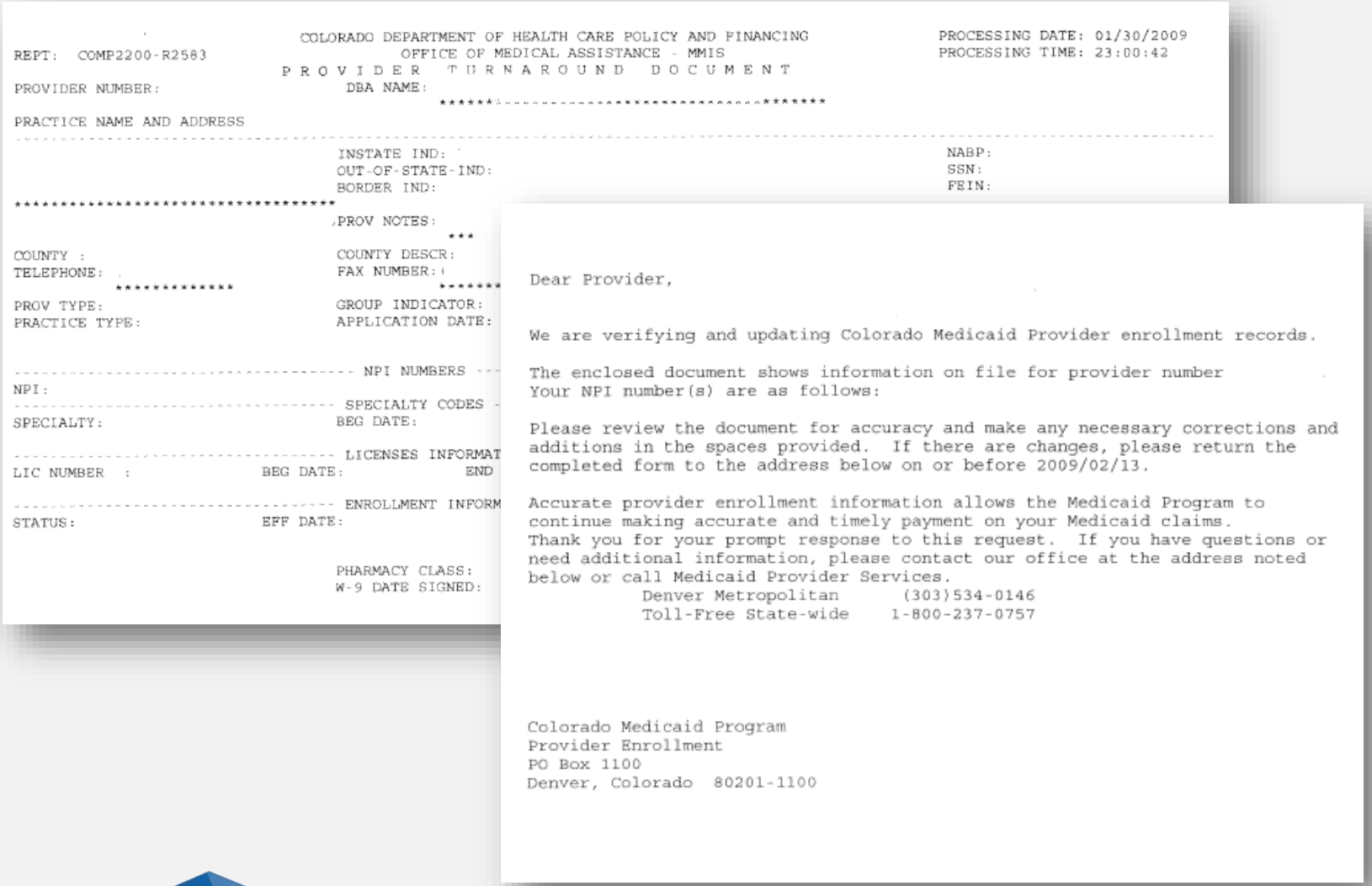
If you have questions about your enrollment or participation in the Colorado Medicaid Program, please call Medicaid Provider Services.

Denver Metropolitan	(303)534-0146
Toll-Free State-wide	1-800-237-0757

Please notify the Medicaid Program promptly if information on your enrollment application changes -- particularly changes of address, tax reporting information, and group affiliations, etc. For your protection, requests for enrollment changes must be made in writing and sent to the address below.

Colorado Medicaid Program
Provider Enrollment
PO Box 1100
Denver, Colorado 80201-1100

Turn Around Document



COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
OFFICE OF MEDICAL ASSISTANCE - MMIS
PROVIDER TURNAROUND DOCUMENT

REPT: COMP2200-R2583
PROCESSING DATE: 01/30/2009
PROCESSING TIME: 23:00:42

PROVIDER NUMBER:
DBA NAME:

PRACTICE NAME AND ADDRESS

INSTATE IND:
OUT-OF-STATE-IND:
BORDER IND:
NABP:
SSN:
FEIN:

PROV NOTES:

COUNTY :
TELEPHONE:
COUNTY DESCR:
FAX NUMBER:

PROV TYPE:
PRACTICE TYPE:
GROUP INDICATOR:
APPLICATION DATE:

NPI NUMBERS
NPI:

SPECIALTY CODES
SPECIALTY:
BEG DATE:

LICENSES INFORMAT
LIC NUMBER :
BEG DATE:
END

ENROLLMENT INFORM
STATUS:
EFF DATE:

PHARMACY CLASS:
W-9 DATE SIGNED:

Dear Provider,

We are verifying and updating Colorado Medicaid Provider enrollment records.

The enclosed document shows information on file for provider number
Your NPI number(s) are as follows:

Please review the document for accuracy and make any necessary corrections and additions in the spaces provided. If there are changes, please return the completed form to the address below on or before 2009/02/13.

Accurate provider enrollment information allows the Medicaid Program to continue making accurate and timely payment on your Medicaid claims.
Thank you for your prompt response to this request. If you have questions or need additional information, please contact our office at the address noted below or call Medicaid Provider Services.

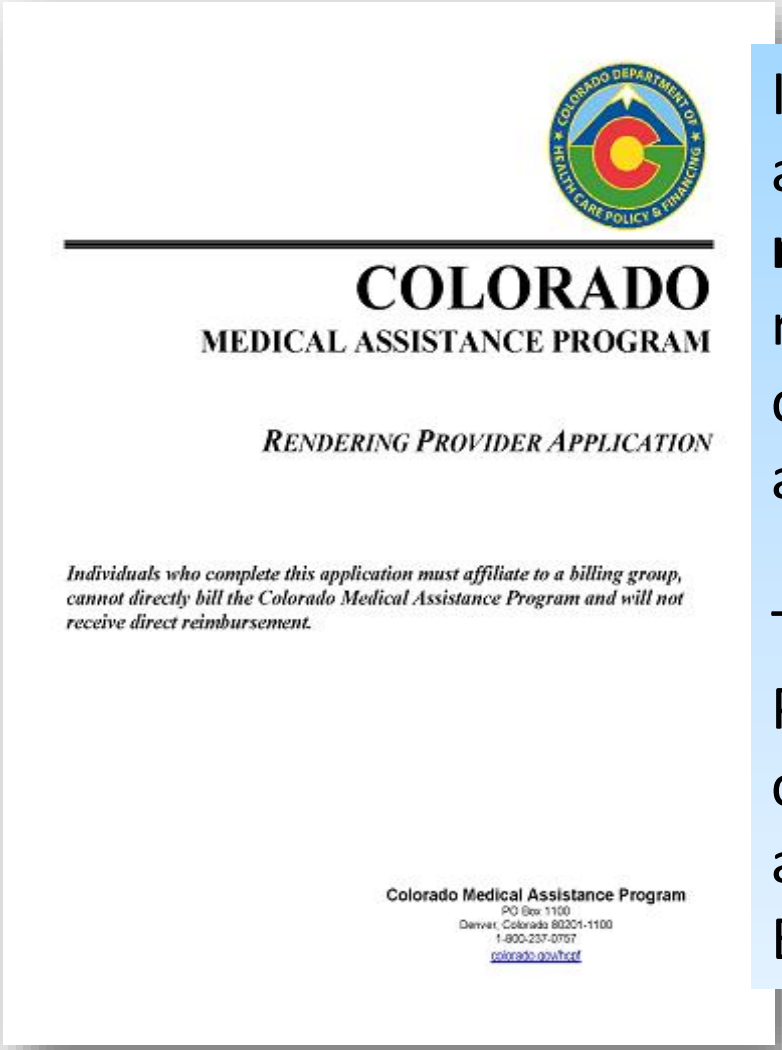
Denver Metropolitan (303)534-0146
Toll-Free State-wide 1-800-237-0757

Colorado Medicaid Program
Provider Enrollment
PO Box 1100
Denver, Colorado 80201-1100

Approved Enrollment

- Provider receives Web Portal password from State within 3-4 weeks of acceptance
- Processing Electronic Funds Transfer (EFT) form can take up to 30 business days
  - Note: Provider will receive paper warrants until EFT information is processed
  - Contact **your** financial institution to verify EFT completion

Rendering Provider Application



COLORADO

MEDICAL ASSISTANCE PROGRAM

RENDERING PROVIDER APPLICATION

Individuals who complete this application must affiliate to a billing group, cannot directly bill the Colorado Medical Assistance Program and will not receive direct reimbursement.

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

Individual applicants who will affiliate with a group and will **not** receive direct reimbursement must complete **Rendering Provider** application

The fillable Rendering Provider application can be completed online, printed, and mailed to Provider Enrollment

Rendering Provider Application

Physician Assistants and Registered Nurses:

- must complete the Rendering Provider Application
- cannot bill directly

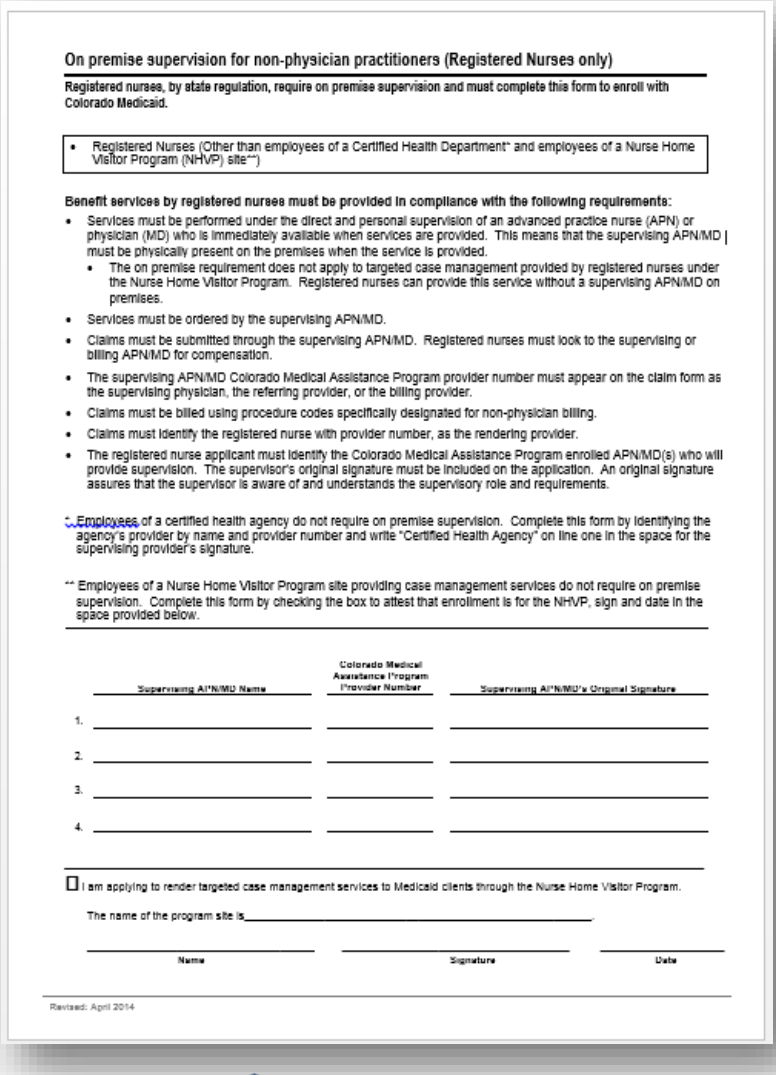
Individual or group providers requesting direct reimbursement:

- must complete Standard Provider Application

Substance Use Disorder (SUD) providers:

- must complete Standard Provider Application

On Premise Supervision Form



On premise supervision for non-physician practitioners (Registered Nurses only)

Registered nurses, by state regulation, require on premise supervision and must complete this form to enroll with Colorado Medicaid.

- Registered Nurses (Other than employees of a Certified Health Department* and employees of a Nurse Home Visitor Program (NHVP) site**)

Benefit services by registered nurses must be provided in compliance with the following requirements:

- 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.
  - 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.
- Services must be ordered by the supervising APN/MD.
- Claims must be submitted through the supervising APN/MD. Registered nurses must look to the supervising or billing APN/MD for compensation.
- 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.
- Claims must be billed using procedure codes specifically designated for non-physician billing.
- Claims must identify the registered nurse with provider number, as the rendering provider.
- The registered nurse applicant must identify the Colorado Medical Assistance Program enrolled APN/MD(s) who will provide supervision. The supervisor's original signature must be included on the application. An original signature assures that the supervisor is aware of and understands the supervisory role and requirements.

* Employees of a certified health agency do not require on premise supervision. Complete this form by identifying the agency's provider by name and provider number and write "Certified Health Agency" on line one in the space for the supervising provider's signature.

** Employees of a Nurse Home Visitor Program site providing case management services do not require on premise supervision. Complete this form by checking the box to attest that enrollment is for the NHVP, sign and date in the space provided below.

	Supervising APN/MD Name	Colorado Medical Assistance Program Provider Number	Supervising APN/MD's Original Signature
1.			
2.			
3.			
4.			

☐ I am applying to render targeted case management services to Medicaid clients through the Nurse Home Visitor Program.

The name of the program site is _____.

Name _____ Signature _____ Date _____

Revised: April 2014

This form is required for Registered Nurses (RN) and must be returned with application

Supervising Physicians (MD) or Advanced Practice Nurses (APN)

Except as listed, benefit services provided by RNs must comply with these requirements:

Services must be performed under direct & personal supervision of an APN or MD who is immediately available when services are provided

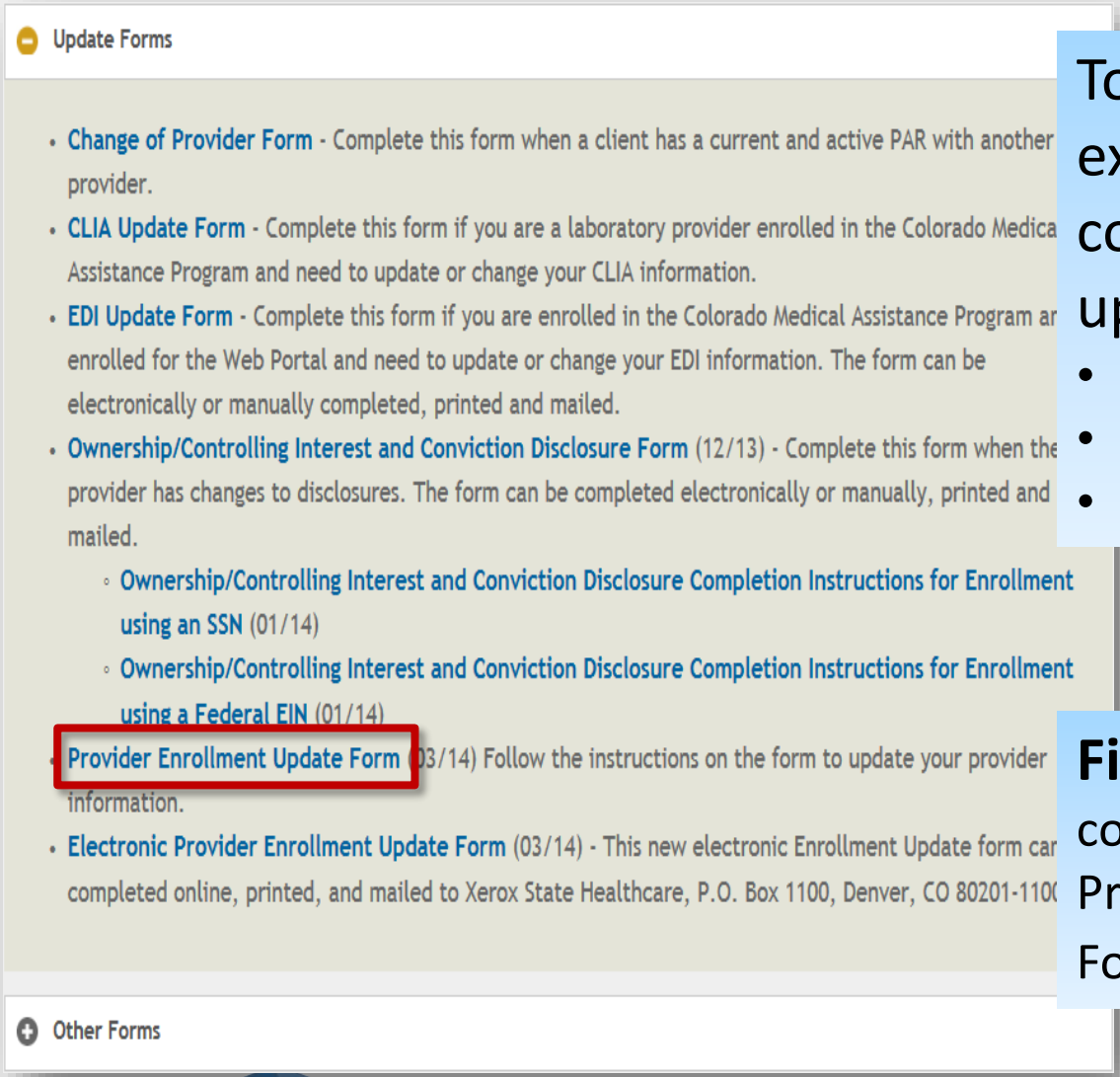
Licensed APN or MD must order services

An enrolled APN, MD or clinic must submit RN claims and is responsible for reimbursing RN

Supervising APN or MD provider number must appear on claim form as supervising physician, referring provider, or billing provider

Claims must be submitted using specific non-physician billing codes and identify RN's provider number as rendering provider

Enrollment Updates



To make changes to an existing provider profile, complete & submit these update forms:

- CLIA
- EDI
- Provider Enrollment

Find the forms here:
colorado.gov/hcpf/For Our Providers/Provider Services/ Forms/Update Forms

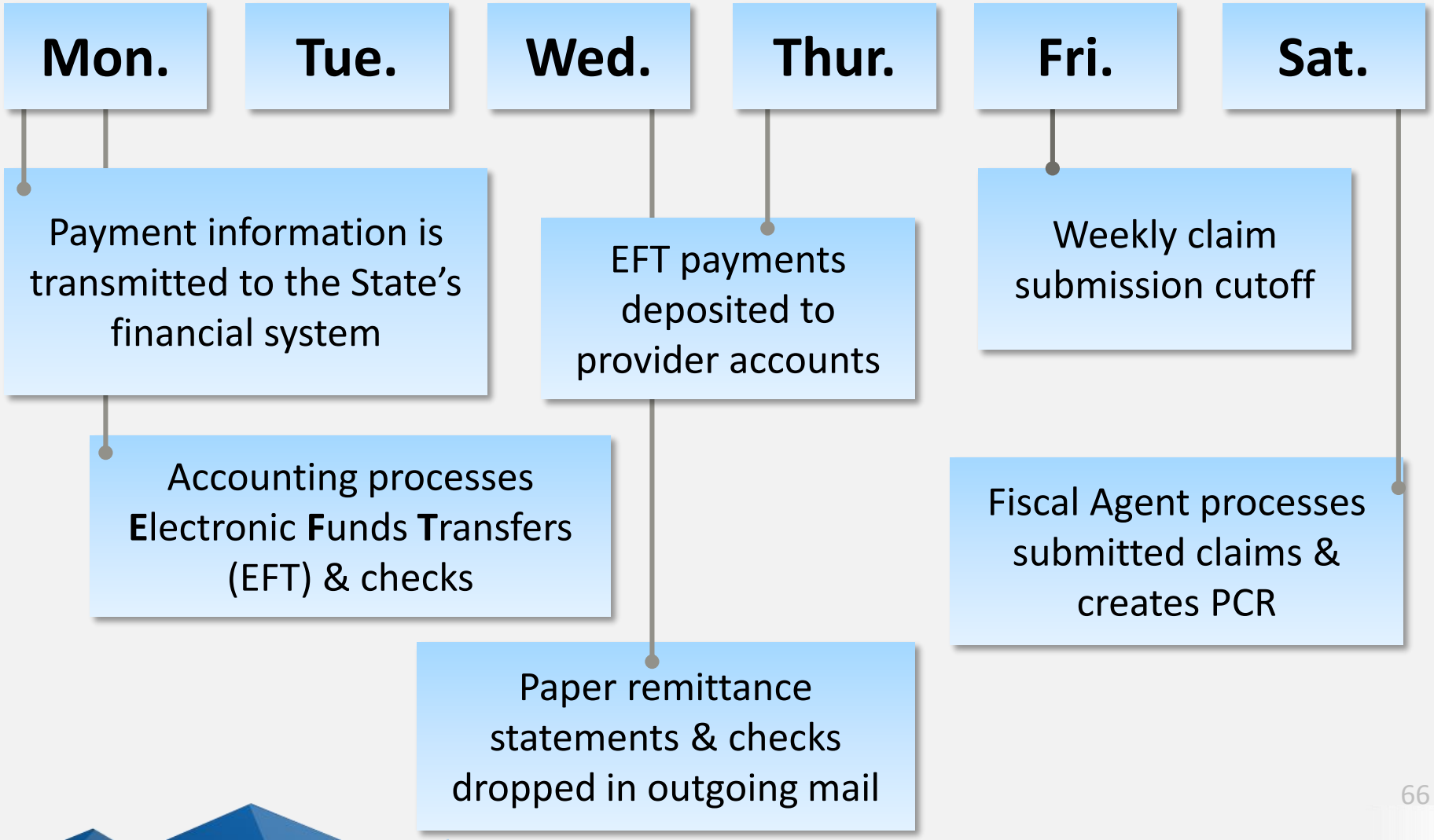
Next Steps

Once enrolled as a Colorado Medical Assistance Program provider, please join us for any of our classes to learn:

- Beginning Billing
- Practitioner Billing
- Hospital Billing
- Specialty Billing

Schedules can be found here:
Department website » For Our Providers » Provider Services » Training » Billing Training & Workshops or in current Provider Bulletin

Payment Processing Schedule



Contact Information

Mail All Enrollment Documents to:

Xerox State Healthcare
Provider Enrollment
P.O. Box 1100
Denver, Colorado 80201-1100

For further assistance with enrollment or to check an enrollment status please contact:

Xerox State Healthcare Provider Services Call Center
1-800-237-0757

Thank You!