COLORADO
Department of Health Care Policy & Financing

gainwell

Change of Ownership Form

The selling entity must submit this form with their disenrollment request to complete a change of ownership.

Provider Request

Under Paragraph S of the Provider Participation Agreement, an enrolled provider is required to notify the Department of Health Care Policy and Financing within 35 days of any substantial change which includes a change of ownership. **A new enrollment is required when a new tax identification number is issued.** (Ownership or managing employee changes where the tax identification number doesn't change, requires disclosure updates for the existing enrollment that can be submitted via a maintenance request using the Provider Portal.)

Effective date of the change of ownership: _____

New Provider Name & Address (Purchasing Entity):

Name: _____

Phone Number: _____

Email: _____

Address: _____

_____

_____

Existing Provider Name (Selling Entity):

Name: _____

Provider ID: _____

NPI: _____

Existing Provider Forwarding Address (Selling Entity):

Name: _____

Phone Number: _____

Email: _____

Address: _____

_____

_____

Name & Address of party responsible for maintaining records pursuant to 10 C.C.R. 2505-10, Section 8.130.2:

Name: _____

Phone Number: _____

Email: _____

Address: _____

_____

_____

Name & Address of party responsible for any financial liabilities that were caused prior to the effective date of the change of ownership or EIN:

Name: _____

Phone Number: _____

Email: _____

Address: _____

_____

_____

A change of ownership terminates the existing Provider Participation Agreement. No claims may be submitted by the seller for dates of services rendered on or after the effective date for the change of ownership.

New owners must complete a new application and Provider Participation Agreement (included as part of the application) to participate in Health First Colorado (Colorado's Medicaid Program).

Provider/Provider Representative Name (please print): _____

Provider/Provider Representative Signature: _____ *Date:* _____

Contact the Provider Services Call Center with any questions regarding Health First Colorado (Colorado's Medicaid Program) enrollment.

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