COLORADO
Department of Health Care Policy & Financing

Health First Colorado (Colorado's Medicaid Program)

Dental Provider Certification

Provider Request

This is to certify that the foregoing information is true, accurate, and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification or concealment of material fact may be prosecuted under Federal and State Laws.

Provider/Provider Representative Name (please print): ____

Provider/Provider Representative Signature: ___________________________ *Date:* ________________

Contact Information: Phone: ____________________ *Email:* ________________________________

This document is an addendum to the American Dental Association (ADA) dental claim forms, and this document is required per 42 C.F.R. 455.18 (a) (1-2) and to be attached to dental claims that are submitted for payment by paper.

Revised: November 2020