**Health First Colorado (Colorado’s Medicaid Program)**

**Dental Provider Certification**

<table>
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<tr>
<th>Provider Request</th>
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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 2021

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Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

[hcpf.colorado.gov](http://hcpf.colorado.gov)