COLORADO
Department of Health Care Policy & Financing

gainwell

Change Enrollment Type Form

Complete this form to request an enrollment type change for an existing individual provider.

Provider Request

Note: The provider type (e.g., Physical Therapist, Podiatrist, Psychologist) cannot be changed.

Provider Name (Individual): _____

National Provider Identifier (NPI): _____

Health First Colorado Provider ID (Medicaid ID):_____

Desired Enrollment Type Change (select one):

☐ Ordering, Referring, or Prescribing Provider to Individual Within a Group **(Must attach copy of license)**

Affiliation: Group name _____ **Group ID** _____

☐ Individual Within a Group to Billing Individual **(This form must be included with an EFT Request and W9)**

☐ *I attest that the information provided is complete and accurate.*

Provider/Provider Representative Name (please print): _____

Provider/Provider Representative Signature: _____

Date: _____

Contact Information:

Phone: _____ **Email:** _____

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