303 E. 17th Avenue
Denver, CO 80203

Colorado Emergency Medical Services (EMS) Supplemental Payment Annual Provider Participation Agreement State Fiscal Year (FY) 2023-24

Statement of Intent

The purpose of this agreement is to allow participation in the CO EMS Supplemental Payment by the governmentally owned or operated provider, named below, subject to the provider's compliance with the requirements and responsibilities set forth in this agreement.

CO EMS Supplemental Payment Provider Responsibilities

A. Submit the Provider Participation Agreement form.

B. Attending one cost report annual training is highly encouraged to ensure efficient and accurate cost reporting.

C. Utilize the Supplemental Payment email address (COEMSsupplemental@pcgus.com) and hotline (877-775-3867) to ensure understanding and completion of the annual cost report.

D. Submit cost report by November 27, 2024, and certify all costs on the Ambulance Services Cost Report (ASCR) portal.

E. Maintain documentation of all amounts claimed pursuant to this agreement to permit a determination of expense allowability and for possible reviews and audits by state and federal agencies.

F. Agree to accept as payment in full the reimbursement received for services subject to supplemental reimbursement pursuant to this agreement. Under no circumstances will the total amount of reimbursement received exceed one hundred percent of actual costs.

G. Provider agrees that the Department is not responsible for the compliance of costs reported by the governmentally owned and operated provider.

COLORADO
Department of Health Care Policy & Financing

303 E. 17th Ave. Suite 1100
Denver, CO 80203

Colorado Emergency Medical Services (EMS) Supplemental Payment Annual Provider Participation Agreement State Fiscal Year (FY) 2023-24

Important Instructions: Complete all fields below including signature and date fields. Access to the Ambulance Services Cost Report Portal FY 2023-24 cost report will be delayed without a completed form.

First and Last Name:

Title:

Email Address:

Phone Number:

Street Address:

City, State and Zip:

Provider Name:

Doing Business As (dba):

Provider NPI:

Additional NPI (if applicable):

Additional NPI (if applicable):
Provider Authorized Representative's Signature:

Date:

Return both pages of the completed Participation Agreement to the Department of Health Care Policy and Financing, Attn: Olga Gintchin, olga.gintchin@state.co.us.
Please notify us if your banking information has changed since last year or if this will be your first year receiving the supplemental payment.