gainwell

Fingerprint Criminal Background Check Other State and/or Medicare Information Form

Complete this form if fingerprints were submitted and approved by Medicare or another State Medicaid Agency. Type or print clearly.

Provider Request

Provider ID Number:__________________

Provider Name (Business or Individual):____

Location Address:______________________________________ Address Line 2:_______________________

City:________________________________ State:_________________________Zip Code:_______________

List all individual(s) with 5% or more ownership/control interest. Include the last four (4) digits of social security number (SSN). Attach a separate page if needed to list additional individuals.

Individual Name	Last Four Digits of SSN	Fingerprints Submitted to Medicare	Other State Medicaid	States
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	
		Yes ☐ No ☐	Yes ☐ No ☐	

*Contact Name: (please print):*____

*Contact Name Signature:*____*Date:*________________

*Contact Information: Phone:*__________________*Email:*____

Complete form and mail to:
Gainwell Technologies
Attention: Provider Enrollment - Fingerprints
P.O. Box 30
Denver, CO 80201

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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.
www.colorado.gov/hcpf