



Provider Revalidation Manual

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Please read before starting the revalidation application.

It is important to review the information in the provider profile before starting the Revalidation application. Not all information may be edited during completion of the Revalidation application. If any information is not current, please follow the process to submit a maintenance request to update the information prior to beginning revalidation. Once the maintenance request is approved, and the updated information displays in the provider profile, please select the “Revalidation” link to begin the Revalidation application. Providers are permitted to have only one request submitted for review at a time.

This manual is designed to serve as a step-by-step guide to follow while completing the Revalidation application.

This guide is targeted toward users who are already familiar with the enrollment process. If the user is new to the enrollment process, it will be helpful to review the [Provider Enrollment Manual](#) for additional information such as definitions of the fields within each panel.

Introduction

Child Health Plan *Plus* (CHP+) and Health First Colorado (Colorado’s Medicaid Program) providers must revalidate in the program at least every five (5) years to continue as a provider. HB 18-1282 requires newly enrolling and currently enrolled organization health care providers (not individuals) to obtain and use a unique National Provider Identifier (NPI) for each service location and provider type enrolled in the Colorado interChange. Providers will be contacted via email approximately six (6) months prior to their revalidation deadline. The deadline is based on the date the enrollment application was approved.

Much of the information needed for the Revalidation application will be pre-populated and will not be editable during completion of the Revalidation application. Providers are strongly encouraged to review the profile before beginning revalidation and submit a maintenance request if any information needs to be updated. This will expedite the revalidation process.

If the provider has been assigned a tracking number for the Revalidation application, then determines that un-editable information must be updated, the provider must wait until the revalidation is approved or denied. Once the Revalidation application has been approved, providers will be able to submit a maintenance request to update the information.

Before Beginning

To navigate through the revalidation application in the Provider Web Portal, please have the latest version of one of the following web browsers installed on the personal computer (PC).

- Microsoft Internet Explorer Version 9.0 and later
- Mozilla Fire Fox
- Safari

- Google Chrome

Also required is Adobe Flash Player 10.0 or later for document viewing.

More Information on a Field

Throughout the Revalidation process a red asterisk * next to a field indicates that it is required information.

In certain fields, additional information can be found by hovering the cursor over the exclamation point. Hovering over this will open a gray box that gives more information about the field. The gray information box will disappear when the cursor is moved.



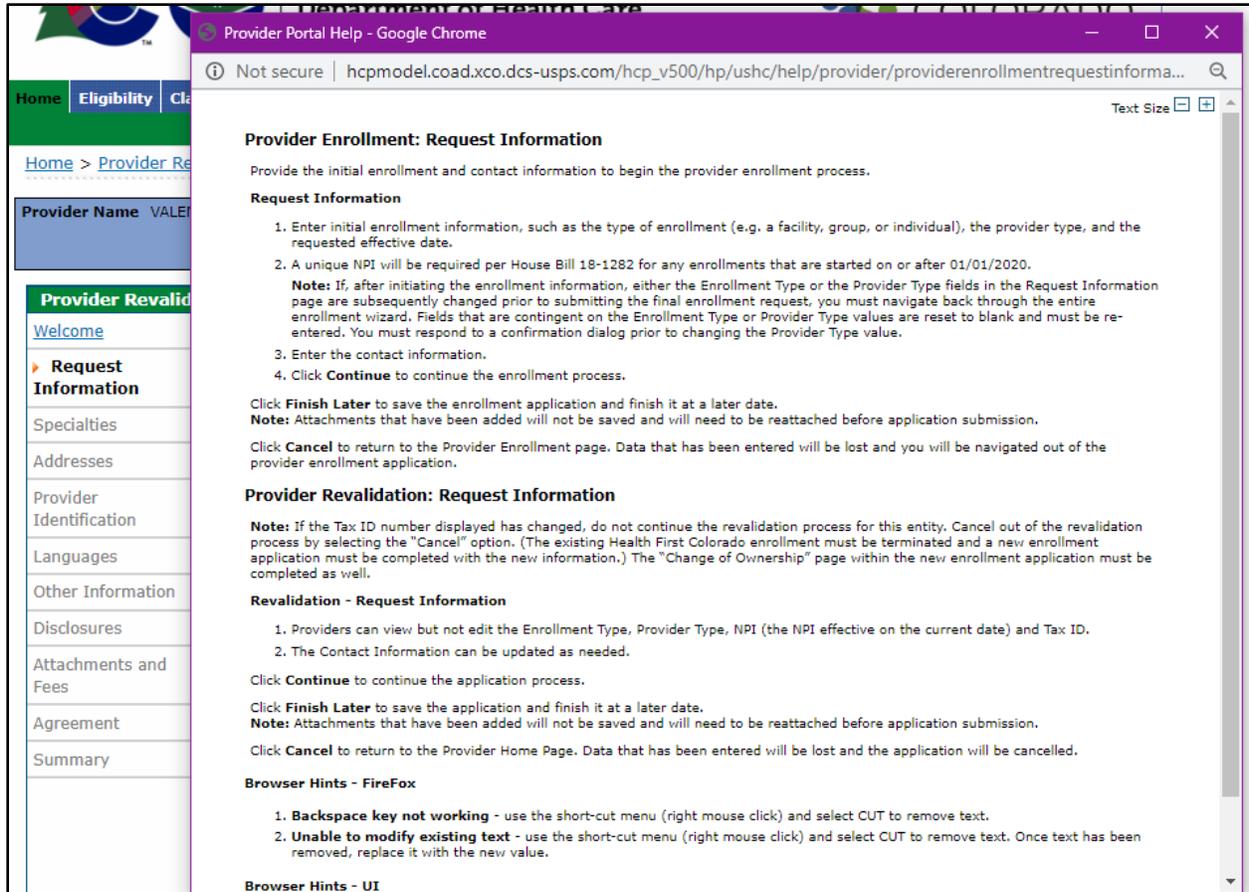
* Provider Type 

* Provider Type 

Enter 2 or more characters to begin search. Select entry from list.

Help Feature on Each Page

Throughout the revalidation process there is a question mark  symbol towards the top right corner of each page. Clicking on it will open a dialog help window specific to the screen the user is currently in: 



Key Facts

Prior to beginning the revalidation process, having the following information available will help make the process quicker. **Additional requirements will vary depending on the provider type & enrollment type.**

Please visit the [Revalidation Information by Provider Type web page](#) to view additional requirements for the provider type and specialty.

Mailing Address – This address is where paper Prior Authorization Request (PAR) letters are sent if the provider is not receiving PAR letters electronically.

Billing Address – This address is where paper checks and remittance advice statements are sent if the provider is not receiving them electronically.

License Number (if applicable) – This is the identification number assigned by licensing agencies. Be sure to enter all alphanumeric characters, dots and dashes of the license number and attach a copy.

Certification Information (if applicable) – This is for any additional certifications the provider would like included in the profile. Be sure to include all alphanumeric characters of the certificate number and attach a copy.

Malpractice & Liability Insurance Information – Complete the insurance information.

Note: Nursing facilities are required to attach a copy of the current insurance face sheet.

Ownership/Controlling Interest & Conviction Disclosure Information

For each person or entity with an ownership or controlling interest of 5% or more in the enrolling provider (as well as Board of Directors with 0% ownership for a corporation, LLC, or non-profit, or local management structure for government agencies) the following information is needed:

- Name
- Address
- Federal Employer ID Number (EIN) or Social Security Number (SSN) - for individuals
- Date of birth (DOB) if individual

Completing the Revalidation Application

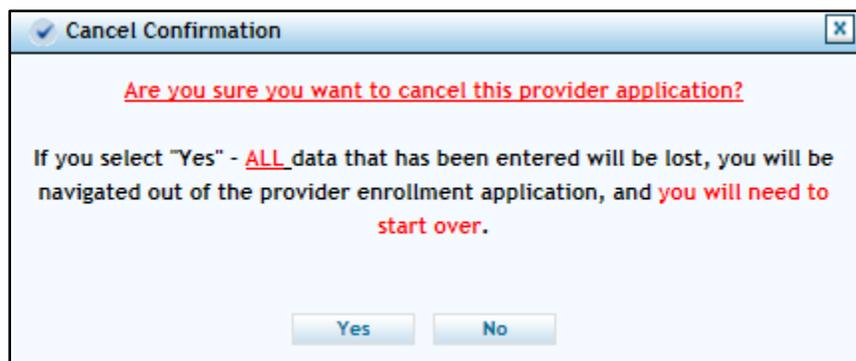
While completing the application, the user will see three buttons available at the bottom of each panel.



These buttons allow the user to:

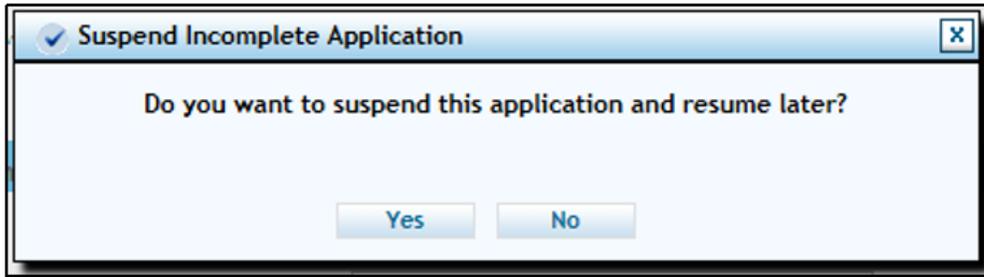
Continue – Continue to the next panel of the Revalidation application.

Cancel – Stops the application process without saving the information. Clicking this button will prompt the end of the application process without saving the data. Please note that a confirmation notification to cancel will appear before the user is permitted to proceed.



Finish Later – Saves the information and allows the user to come back to the application later.

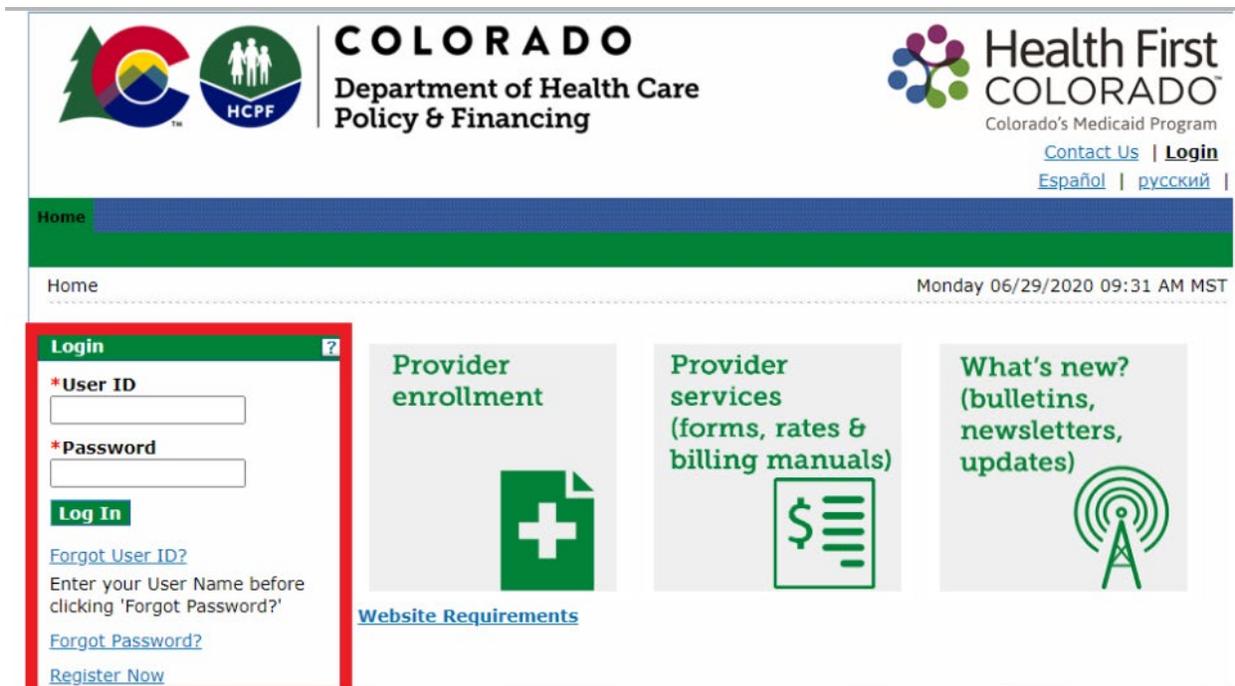
Suspend Incomplete Application Pop Up



Select “No” and the user will return to the application process. Select “Yes” and you will be logged out of the Revalidation application and assigned a tracking number to the Revalidation application. **It is important to retain the application tracking number (ATN) for future use.**

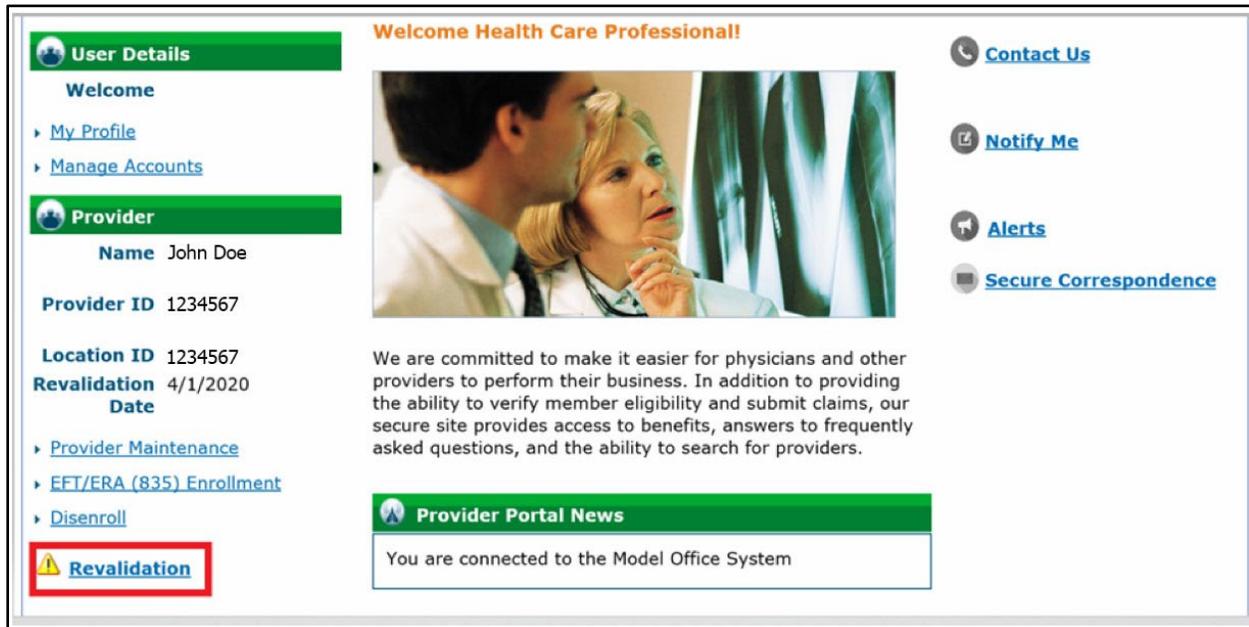
Accessing the Provider Web Portal

Login to [Provider Web Portal](#).



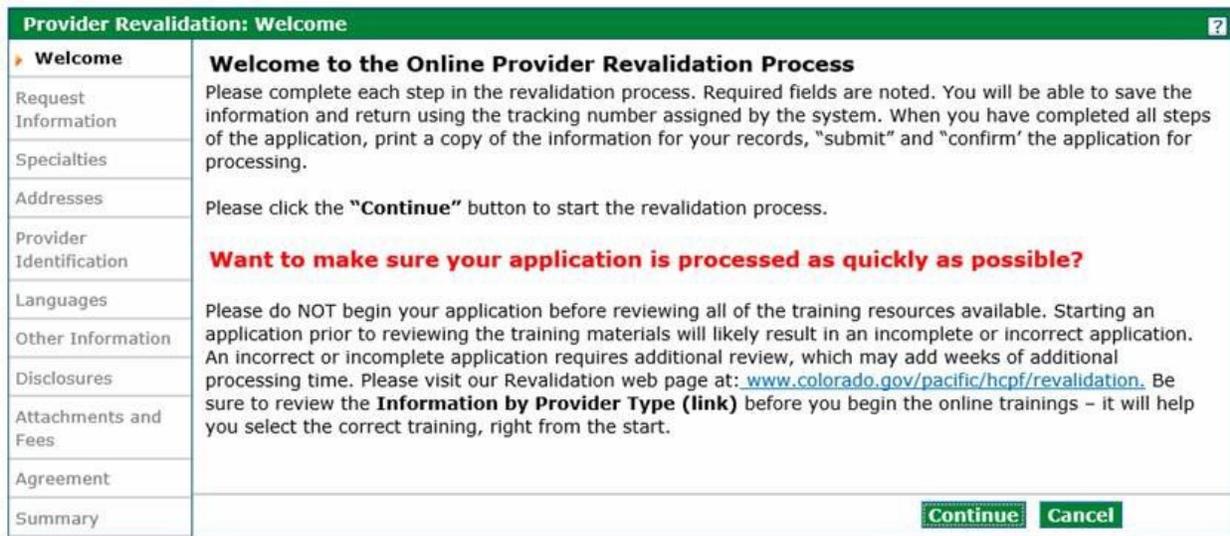
Click “Revalidation” as shown in the next screenshot.

The date that displays next to the “Revalidation Date” field is the date that the provider is due to complete revalidation.



This will direct providers to the **Welcome** panel of revalidation.

Welcome Panel



Once the information has been reviewed, click the “Continue” button to start Revalidation.

Request Information Panel

After clicking the “Continue” button, the Request Information Panel will be displayed.



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Home > [Provider Revalidation](#) > Revalidation Request Information
Friday 10/02/2020 10:50 AM MST

Provider Name Medical Provider
Provider ID Providers - 1234567891 (NPI)
Location 00000000 - Medical Provider

Taxonomy 1234Z20000FL

Provider Revalidation: Request Information
?

[Welcome](#)

Request Information

Specialties

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Summary

You are revalidating your enrollment application. Below is the current information. Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later". The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application.

* Indicates a required field.

Initial Enrollment Information

Enrollment Type Group

Provider Type 35-Community Mental Health Center

Provider Information

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required. If the below EIN is incorrect you must complete a new enrollment application. The existing Colorado Medicaid enrollment associated to the old EIN must be terminated by completing the Change of Ownership option from the menu items listed within the new application. Please cancel out of this process and begin a new enrollment.

NPI 1234567891 **MCD** 1234567

NPI Zip + 4 88888-1234 **Taxonomy** 1234Z20000FL -Clinic/Center - Mental Health (Including Community Mental Health Center)

Tax ID Number 1234567 **Tax ID Type** EIN

Contact Information

*Last Name

*First Name

Suffix

*Phone Ext

Fax Number

*Contact Email

*Confirm Email

*Email For Provider Publications

*Confirm Email

Preferred Method of Communication

Continue
Finish Later
Cancel

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Within this panel the provider must verify that contact information is current, and if necessary, update the information. This is the contact person who may be contacted to answer questions regarding the Revalidation application.

Fields that are view only:

- Provider's NPI
- Medicaid ID (MCD)
- NPI Zip +4
- Taxonomy
- Tax ID Number
- Tax ID type (EIN or SSN)

If the NPI is matched to another actively enrolled provider location the user will not be able to continue with the application until the error is resolved.

If the Tax ID is a Social Security Number (SSN) and there is another actively enrolled provider in the system with the same SSN, the user will not be able to continue with the revalidation process. Individuals (SSNs) are limited to one (1) enrollment.

Specialties Panel



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Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 000000000 - Medical Provider

Taxonomy 363LF0000X

Provider Revalidation: Specialties ?

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Specialties

Specialties can be updated after the Revalidation Application has been approved by submitting a provider maintenance request.

| | Specialty | Taxonomy | Effective Date | End Date |
|-------------------------------------|--------------------------------------|--|----------------|----------|
| <input checked="" type="checkbox"/> | Physician | Preventive Medicine - Medical Toxicology | 01/01/2019 | |
| <input type="checkbox"/> | Click to add additional specialties. | | | |

Additional Taxonomies (if applicable)

Additional Taxonomies can be updated after the Revalidation Application has been approved by submitting a Provider Maintenance request.

Taxonomy

Click to collapse.

Taxonomy

[Add](#)

Continue
Finish Later
Cancel

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Specialties and Additional Taxonomies may not be updated during revalidation. Specialties and Additional Taxonomies may be added with a separate maintenance request after the revalidation is completed.

Addresses Panel



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Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 0000000000 - Medical Provider

Taxonomy 363LF0000X

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* Indicates a required field.

Provider Addresses

The provider addresses identify the location where a provider renders services, as well as locations that are used for billing and payment.

All Providers must enter a Service Location, Billing, and Mailing address.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

| Type | Address | City | State | Action |
|---|-----------|--------|----------|--------|
| <input type="checkbox"/> Service Location | 648 FIRST | DENVER | Colorado | |
| <input type="checkbox"/> Billing | 648 FIRST | DENVER | Colorado | |
| <input type="checkbox"/> Mailing | 648 FIRST | DENVER | Colorado | |

You have reached the maximum number of addresses allowed for this list.

Continue
Finish Later
Cancel

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Within this panel the provider may update:

- Billing Address
- Mailing Address

If updating the Billing or Mailing address, select the drop-down to update the information. Select "Save" to save the updated information. Select "Reset" to refresh the information. Select "Cancel" to cancel the update within this section.

| | | | | | | |
|---|---|------------------|-----------|----------|----------|--|
| Other Information | <input type="checkbox"/> | Service Location | 648 FIRST | DENVER | Colorado | |
| Disclosures | <input type="checkbox"/> | Billing | 648 FIRST | DENVER | Colorado | |
| Attachments and Fees | *Address Type <input type="text" value="Billing"/> | | | | | |
| Agreement | *Location Code <input type="text" value="In-State"/> | | | | | |
| Summary | *Pay To Name <input type="text" value="B"/> | | | | | |
| *Address <input type="text" value="648 FIRST"/> | | | | | | |
| *City <input type="text" value="DENVER"/> County <input type="text" value="Other"/> | | | | | | |
| *State <input type="text" value="Colorado"/> *Zip Code <input type="text"/> | | | | | | |
| Primary Email <input type="text" value="johndoe@johndoe.com"/> Confirm Email <input type="text" value="johndoe@johndoe.com"/> | | | | | | |
| Secondary Email <input type="text"/> Confirm Email <input type="text"/> | | | | | | |
| Phone <input type="text" value="Office"/> <input type="text" value="1234568790"/> Ext <input type="text"/> Phone <input type="text"/> <input type="text"/> Ext <input type="text"/> | | | | | | |
| Phone <input type="text"/> <input type="text"/> Ext <input type="text"/> Phone <input type="text"/> <input type="text"/> Ext <input type="text"/> | | | | | | |
| <input type="button" value="Save"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/> | | | | | | |
| <input type="checkbox"/> | Mailing | 648 FIRST | DENVER | Colorado | | |
| You have reached the maximum number of addresses allowed for this list. | | | | | | |
| <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> | | | | | | |

Fields that are view only:

- Service Location address

Provider Identification Panel



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Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 000000000 - Medical Provider

Taxonomy 363LF0000X

Provider Revalidation: Provider Identification ?

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Summary

* Indicates a required field.

Provider Legal Name

The provider legal name and information is provided once for each enrollment.

* **Last Name**

* **First Name**

Middle **Suffix**

Individual Providers

* **Gender** * **Birth Date**

Fields marked required in this section are only required if any information is entered in this section. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| Degree | School | Year of Graduation | Action |
|--|--------|--------------------|--------|
| <input type="checkbox"/> Click to collapse. | | | |
| * Degree <input type="text"/> * School <input type="text"/> * Year of Graduation <input type="text"/> | | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | |

License

Fields marked required in this section are only required if any information is entered in this section. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the

Initial view of licenses (nothing is expanded):

| License | | | | | |
|--|-----------|----------------|-----------------|----------|--------|
| Primary license data must be entered if required for the selected provider type and specialties. Non-required licenses may be added and indicated as secondary. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row. | | | | | |
| | License # | Effective Date | Expiration Date | Status | Action |
| <input type="checkbox"/> | CO1234 | 01/01/2020 | 12/31/2021 | Inactive | |
| <input type="checkbox"/> | CO1234 | 01/01/2022 | 12/31/2023 | Active | |
| <input type="checkbox"/> Click to add license | | | | | |

Expanded view of expired and active license records:

| License | | | | | |
|--|-----------|---|-----------------|----------|--------|
| Primary license data must be entered if required for the selected provider type and specialties. Non-required licenses may be added and indicated as secondary. Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row. | | | | | |
| | License # | Effective Date | Expiration Date | Status | Action |
| <input type="checkbox"/> | CO1234 | 01/01/2020 | 12/31/2021 | Inactive | |
| Enter the entire license ID including alpha, numeric, dots, dashes, etc. | | | | | |
| License # CO1234 | | Description SUD License | | | |
| Effective Date 01/01/2020 | | Expiration Date 12/31/2021 | | | |
| Issuing State Colorado | | Issuing Authority Colorado DORA | | | |
| Type Primary | | Status Inactive | | | |
| <input type="checkbox"/> | CO1234 | 01/01/2022 | 12/31/2023 | Active | |
| Enter the entire license ID including alpha, numeric, dots, dashes, etc. | | | | | |
| License # CO1234 | | Description SUD License | | | |
| Effective Date 01/01/2022 | | *Expiration Date <input type="text" value="12/31/2023"/> | | | |
| Issuing State Colorado | | Issuing Authority Colorado DORA | | | |
| *Type <input type="text" value="Primary"/> | | Status Active | | | |
| <div style="display: flex; justify-content: space-around;"> Save Reset Cancel </div> | | | | | |
| <input type="checkbox"/> Click to add license | | | | | |

Adding a new license:

License

Primary license data must be entered if required for the selected provider type and specialties. Non-required licenses may be added and indicated as secondary.
 Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| | License # | Effective Date | Expiration Date | Status | Action |
|---|-----------|----------------|-----------------|----------|--------|
| + | CO1234 | 01/01/2020 | 12/31/2021 | Inactive | |
| + | CO1234 | 01/01/2022 | 12/31/2023 | Active | |

- Click to collapse.

Enter the entire license ID including alpha, numeric, dots, dashes, etc.

If renewing an existing license, select the license record

| | |
|--|---|
| <p>*License # <input style="width: 100%;" type="text"/></p> <p>*Effective Date <input style="width: 80%;" type="text"/> <input style="width: 20px;" type="button" value="⌘"/></p> <p>*Issuing State <input style="width: 80%;" type="text"/> <input style="width: 20px;" type="button" value="v"/></p> <p>*Type <input style="width: 80%;" type="text"/> <input style="width: 20px;" type="button" value="v"/></p> | <p>Description <input style="width: 100%;" type="text"/></p> <p>*Expiration Date <input style="width: 80%;" type="text"/> <input style="width: 20px;" type="button" value="⌘"/></p> <p>*Issuing Authority <input style="width: 80%;" type="text"/> <input style="width: 20px;" type="button" value="v"/></p> |
|--|---|

Renewing an existing, active license:

License

Primary license data must be entered if required for the selected provider type and specialties. Non-required licenses may be added and indicated as secondary.
 Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| | License # | Effective Date | Expiration Date | Status | Action |
|---|-----------|----------------|-----------------|----------|--------|
| + | CO1234 | 01/01/2020 | 12/31/2021 | Inactive | |
| + | CO1234 | 01/01/2022 | 12/31/2023 | Active | |

- Click to collapse.

Enter the entire license ID including alpha, numeric, dots, dashes, etc.

If renewing an existing license, select the license record CO1234|Colorado

| | |
|--|---|
| License # CO1234 | Description SUD License |
| *Effective Date | *Expiration Date |
| Issuing State Colorado | Issuing Authority Colorado DORA |
| *Type Primary | |

Add
Reset

Medicare Participation

To receive Medical Assistance Program payments for services provided to individuals who have Medicare and Medical Assistance Program benefits, providers must accept assignment of their Medicare claims.

Automatic crossover is an exchange of claim information between Medicare and the Medical Assistance Program. When automatic crossover occurs, providers do not have to submit a crossover claim to the Medical Assistance Program. The Colorado Medical Assistance Program obtains crossover claim information from Colorado Medicare carriers and intermediaries. For automatic crossover to occur, providers must identify their NPI number.

Automatic crossovers should occur when the participant has registered their NPI with Medicare Part A and/or Part B and in the Colorado interChange.

Medicare numbers are no longer used for automatic crossover from Medicare Part A and Part B to the Medical Assistance Program.

Medicare #
Effective Date
Medicare Type

DEA #

When changing your DEA #, supporting documentation is required as an attachment to this request.
Fields marked required in this section are only required if any information is entered in this section.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| | DEA # | Effective Date | End Date | Action |
|---|-------|----------------|----------|--------|
| <input type="checkbox"/> Click to collapse. | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="text-align: left;"> <p>*DEA # <input type="text" value="FC9876543"/></p> <p><input type="button" value="Add"/> <input type="button" value="Reset"/></p> </div> <div style="text-align: left;"> <p>*Effective Date <input type="text" value="07/01/2019"/> <input type="button" value="⊕"/></p> </div> <div style="text-align: left;"> <p>*End Date <input type="text" value="08/31/2022"/> <input type="button" value="⊕"/></p> </div> </div> | | | | |
| <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> | | | | |

Within this panel the provider is able to:

- Review and update the Expiration Date for an existing license.
NOTE: If updating an existing license, the expiration date can be changed to an earlier date, it cannot be extended. Extending the expiration date is considered a renewal.
- Add new license information or renew an existing license (if applicable). Be sure to enter all alphanumeric characters, dots and dashes.
- Review and update DEA End Date.
- Review and update Medicare information.

When updating license or DEA data, attach a current copy to verify the information. Refer to the Attachments and Fees Panel section.

Fields that are view only:

- Provider Legal Name
- Doing Business As name
- Organization Type
- Existing license information (excluding the Expiration Date field)
- Expired license information
- Existing DEA license information (excluding the End Date field)

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Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 0000000000 - Medical Provider
Taxonomy 363LF0000X

Provider Revalidation: Provider Identification

Welcome * Indicates a required field.

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▶ **Provider Identification**

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Provider Legal Name
The provider legal name and information is provided once for each enrollment.

| | |
|----------------------------|------------------|
| Provider Legal Name | Medical Provider |
| Doing Business As | Medical Provider |

Organizational Structure
Select the applicable type of business.

| | |
|--------------------------|---------------------|
| Organization Type | Sole Proprietorship |
|--------------------------|---------------------|

Languages Panel

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Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 0000000000 - Medical Provider
Taxonomy 363LF0000X

Provider Revalidation: Languages

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▶ Languages
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Summary

Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required.
Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| Language | Action |
|---|--------|
| <input type="checkbox"/> Click to collapse. | |
| *Language <input type="text"/> | |
| Add | |

[Continue](#) [Finish Later](#) [Cancel](#)

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Within this panel the provider may review and update the languages spoken within the office or facility. There are currently 60 languages available to choose from. After each language is selected, click the "Add" button. The screen will update and add the selected item to the list of languages.

Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| Language | Action |
|---|--------|
| <input type="checkbox"/> Click to collapse. | |
| *Language <input type="text" value="Danish"/> | |
| <input type="button" value="Add"/> | |



If a language needs to be removed, click the "Remove" link in the "Action" column.

Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required.

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| Language | Action |
|---|------------------------|
| Danish | Remove |
| <input type="checkbox"/> Click to add language. | |



Other Information Panel

Provider Revalidation: Other Information
?

[Welcome](#) Additional information is provided for each enrollment, for group/facility and individual providers.

[Request Information](#) * Indicates a required field.

[Specialties](#)

[Addresses](#)

[Provider Identification](#)

[Languages](#)

Other Information

[Disclosures](#)

[Fingerprinting](#)

[Attachments and Fees](#)

[Agreement](#)

[Summary](#)

Malpractice/General Liability Insurance

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

All Applicants must complete, Malpractice/General liability insurance is mandatory under current State and Federal law.

| Name | Policy ID | Effective Date | Expiration Date | Action |
|--|-----------|----------------|-----------------|--------|
| <input type="checkbox"/> Insurance Carrier | 123456 | 01/01/2019 | 12/31/2019 | |

Click to collapse.

*Carrier Name *Policy ID

*Insurance Type *

*Effective Date *Expiration Date

Certification

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

Enter Certification information if applicable. If certified, please provide the specialty certification number, effective date, and expiration date of certification.

| Specialty | Certificate # | Certification | Effective Date | End Date | Action |
|--|---------------|---------------|----------------|----------|--------|
| <input type="checkbox"/> Click to add certification. | | | | | |

Supplemental Questions -

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE
Medicaid Participation

Medicaid Participation

1. ***Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**
 Yes No
2. ***Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**
 Yes No
3. ***Have you ever been denied enrollment for cause in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)?**
 Yes No
4. ***Has your enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated or revoked for cause?**
 Yes No
5. ***Have you ever been excluded from participation in Medicare, Medicaid and all other Federal health care programs by the Office of the Inspector General, U.S. Department of Health and Human Services?**
 Yes No
6. ***Have you ever been excluded from participation in federal procurement?**
 Yes No
7. ***Do you hold all licenses and certifications as required based on your provider type?**
 Yes No
8. ***Is this license expired, or subject to conditions or restrictions?**
 Yes No
9. ***Have you ever been subject to a payment suspension based on a credible allegation of fraud?**
 Yes No
10. ***Do you currently have an outstanding overpayment of \$1,500 or more that is over 30 days past due, you have not entered into a payment plan for, and is not currently the subject of an appeal?**
 Yes No

An individual enrollment with a provider type 24 Non-physician Practitioner Individual (Registered Nurses only) will have the following section displayed:

On Premise Supervision for non-physician practitioners (Registered Nurses Only)

Registered nurses, by state regulation, require on premise supervision and must complete this form to enroll with Colorado Medicaid.

Registered Nurses (Other than employees of a Certified Health Department* and employees of a Nurse Home Visitor Program (NHVP) site).**

Benefit services by registered nurses must be provided in compliance with the following requirements:

- Services must be performed under the direct and personal supervision of an advanced practice nurse (APN) or physician (MD) who is immediately available when services are provided. This means that the supervising APN/MD must be physically present on the premises when the service is provided.
 - The on premise requirement does not apply to targeted case management provided by registered nurses under the Nurse Home Visitor Program. Registered nurses can provide this service without a supervising APN/MD on premises.
- Services must be ordered by the supervising APN/MD.
- Claims must be submitted through the supervising APN/MD. Registered nurses must look to the supervising or billing APN/MD for compensation.
- The supervising APN/MD Colorado Medical Assistance Program provider number must appear on the claim form as the supervising physician, the referring provider, or the billing provider.
- Claims must be billed using procedure codes specifically designated for non-physician billing.
- Claims must identify the registered nurse with provider number, as the rendering provider.
- The registered nurse applicant must identify the Colorado Medical Assistance Program enrolled APN/MD(s) who will provide supervision.

Add each supervisor's name and NPI in the APN/MD table below. Each supervisor's original signature must be included as an attachment with this enrollment. Click [here](#) to download the supervisor signature form. An original signature assures that the supervisor is aware of and understands the supervisory role and requirements.

* Employees of a Certified Health Agency (CHA) do not require on premise supervision. **Check the "Certified Health Agency" box below and enter the agency's provider name and National Provider Identifier (NPI) in the APN/MD table below. A separate attachment including an original signature is not required for the CHA.**

** Employees of a Nurse Home Visitor Program (NHVP) site providing case management services do not require on premise supervision. **Check the "Nurse Home Visitor Program" box below to attest that enrollment is for the NHVP and enter the name of the Nurse Home Visitor program site. A separate attachment including an original signature is not required for the NHVP.**

Certified Health Agency

Nurse Home Visitor Program **Program Name**

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| Supervising APN/MD | | | | |
|---|-----------|------------|-----|--------|
| | Last Name | First Name | NPI | Action |
| <input type="checkbox"/> Click to collapse. | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Last Name <input type="text"/></p> <p>NPI <input type="text"/></p> </div> <div style="width: 45%;"> <p>First Name <input type="text"/></p> </div> </div> | | | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | |

Within this panel the provider will be able to:

- Review and update Malpractice/General Liability Insurance information.
- Review and update Certification records.
- Answer the Supplemental questions. Each question must have an answer before the provider is permitted to continue.
- Review and update Institutional Bed information. If updating bed information, the license is required to be attached showing the number of hospital beds.
- Review and update the website address.

Registered Nurses are required to complete and attach the RN Supervision form. This may be found on the [Provider Forms](#) page on the Department website under the dropdown heading 'Provider Enrollment and Update Forms'.

When updating certification information, insurance information, or hospital bed information, attach a current copy of the applicable documentation to verify the information. Refer to the Attachments and Fees Panel section.

Disclosures Panel

Each question in the disclosures panel is required to be completed with current information.



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| | | |
|---------------------------------------|---|--|
| Provider Name Medical Provider | Provider ID Providers - 1234567891 (NPI) | Location 000000000 - Medical Provider |
| Taxonomy 363LF0000X | | |

Provider Revalidation: Disclosures ?

| | |
|---|---|
| <ul style="list-style-type: none"> Welcome Request Information Specialties Addresses Provider Identification Languages Other Information <li style="background-color: #0056b3; color: white; padding: 2px;">Disclosures Attachments and Fees Agreement Summary | <p>Privacy Act Notice Statement</p> <p>This statement explains the use and disclosure of information about providers and the authority and purposes for which taxpayer identification numbers, including Social Security Numbers (SSNs) and dates of birth (DOB), may be requested and used. Any information provided in connection with provider enrollment will be used to verify eligibility to participate as a provider and for purposes of the administration of the Colorado Medical Assistance Program. This information will also be used to ensure that no payments will be made to providers who are excluded from participation. Any information may also be provided to the U.S. DHHS Centers for Medicare and Medicaid Services, the Internal Revenue Service, the Colorado Office of the Attorney General, the Medicaid Fraud Control Unit, or other federal, state or local agencies as appropriate. Providing this information is mandatory to be eligible to enroll as a provider with the Colorado Medical Assistance Program, pursuant to 42 C.F.R. § 433.37. Failure to submit the requested information may result in a denial of enrollment as a provider, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Colorado Medical Assistance Program.</p> <p>Ownership/Controlling Interest and Conviction Disclosure</p> <p>Disclosure of information regarding ownership and control and on a provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services programs is required by the Centers for Medicare and Medicaid Services and the Colorado Department of Health Care Policy and Financing pursuant to regulations found at 42 CFR § 455.100 through 42 CFR § 455.106. The following disclosures must be made to Colorado Medicaid utilizing the Disclosure links in the table below.</p> <ul style="list-style-type: none"> ▪ All entities, fiscal agents and managed care entities (see definitions) must disclose the information required in Disclosure A, Disclosure B, Disclosure C, Disclosure D, Disclosure E, and Disclosure F. ▪ Answer all questions. If you do not believe that a question is applicable, you should select a response of "No". If "Yes" is selected, please provide any additional information requested. ▪ For disclosures that require further information than can be submitted using this function, utilizing the Attachments and Fees page, please attach a separate list including the required information. |
|---|---|

Available Revalidation Disclosures

Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

| Disclosure Name | Description | Status |
|--|---|--------|
| A. OWNERSHIP OR CONTROL INTEREST | Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more. | New |
| B. SUBCONTRACTOR OWNERSHIP | Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. | New |
| C. INDIVIDUAL RELATIONSHIPS | Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling. | New |
| D. MANAGING EMPLOYEES | Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity. | New |
| E. BUSINESS RELATIONSHIPS | Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity. | New |
| F. CONVICTIONS OF CRIMINAL OFFENSE | Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs. | New |

Continue
Finish Later
Cancel

R05.00.319 [Privacy Notice](#)

Disclosure A is regarding ownership and controlling interest in the applicant. Indicate the information for each person (individual or corporation) with 5% or more ownership or controlling interest in the applicant. The board of directors or government agency management structure may be applicable, depending on how the business is registered. (Board of Director members or management structure may show 0% ownership). For individual applicants (SSN enrollments) it is recommended to select the “No” option in the first question to indicate that ownership/control interest does not apply to the individual.

Disclosures Panel – Ownership/Controlling Interest Disclosure A

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| # | Disclosure Name | Action |
|---|--------------------|--------|
| <input type="checkbox"/> | Click to collapse. | |
| Disclosure A Information - Ownership/Controlling Interest | | |
| <p>List the name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity. Corporations, LLC, Non-Profits must list Board of Directors and government agencies must list local management structure. Corporate entities must list, as applicable, primary business address, every business location, and P.O. Box address. If you are an individual using a SSN for enrollment, select "No" to indicate that ownership/control interest does not apply.</p> <p>1. *Is there any person (individual or corporation) with an ownership or control interest in the disclosing entity as indicated above? <input type="radio"/> Yes <input type="radio"/> No</p> <p>2. *Is this entity an individual? <input type="radio"/> Yes <input type="radio"/> No</p> | | |
| <input type="button" value="Add"/> | | |

A “Yes” answer will open an additional section as shown below, for the required information to be entered.

Disclosure A Information - Ownership/Controlling Interest

List the name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity. Corporations, LLC, Non-Profits must list Board of Directors and government agencies must list local management structure. Corporate entities must list, as applicable, primary business address, every business location, and P.O. Box address. If you are an individual using a SSN for enrollment, select "No" to indicate that ownership/control interest does not apply.

1. ***Is there any person (individual or corporation) with an ownership or control interest in the disclosing entity as indicated above?**
 Yes No

***% Interest:**

Organization Name: (OR)

First Name:

Middle Initial:

Last Name:

***Street Address:**

***City:**

***State:**

***Zip:**

***SSN/EIN:**

2. ***Is the entity entered above an individual?**
 Yes No

***Date of Birth:**

Click to add new Provider Disclosure

If the entity is an individual owner, then they must select “Yes” to question 2 and enter the individual’s “Date of Birth”, as shown above. If the user selects that the entity is not an individual, but enters information for an individual, the application will be returned to the user to correct the information.

When this information is complete, click the “Add” button and the panel will update as shown below.

Disclosures Panel – Ownership/Controlling Interest Disclosure A – Add or Submit

Answer Enrollment Disclosure Questions
?

Ownership/Controlling Interest and Conviction Disclosure

Disclosure of information regarding ownership and control and on a provider’s owners and other persons convicted of criminal offenses against Medicare, Medicaid, or the title XX services programs is required by the Centers for Medicare and Medicaid Services and the Colorado Department of Health Care Policy and Financing pursuant to regulations found at 42 CFR § 455.100 through 42 CFR § 455.106. The following disclosures must be made to Colorado Medicaid.

- **All entities, fiscal agents and managed care entities** ([see definitions](#)) must disclose the information required in **Disclosure A, Disclosure B, Disclosure C, Disclosure D, Disclosure E, and Disclosure F.**
- **Answer all questions.** If you do not believe that a question is applicable, you should select a response of "No". If "Yes" is selected, please provide any additional information requested.
- For disclosures that require further information than can be submitted using this function, utilizing the Attachments and Fees page, please attach a separate list including the required information.

** Indicates a required field.*

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the **"Add"** button. Click **"Remove"** to remove the entire row.

| # | Disclosure Name | Action |
|---|--------------------------------------|------------------------|
| + | A. OWNERSHIP OR CONTROL INTEREST | Remove |
| + | Click to add new Provider Disclosure | |

↑

→

Submit
Cancel

Continue to add entities as applicable. For additional entries click on the “+” symbol on the left-hand side of the panel.

When all Ownership/Controlling Interest is entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”, as shown below.

Disclosures Panel – Ownership/Controlling Interest Disclosure A – Completed

| Available Enrollment Disclosures | | |
|--|--|---|
| <p>Click the disclosure name to open the disclosure for editing. After completing the disclosure, select "Add". When you have completed the disclosure, click "Submit" to return to the main Disclosures page. All Disclosures must be completed to Continue.</p> | | |
| Disclosure Name | Description | Status |
| A. OWNERSHIP OR CONTROL INTEREST | Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more. | Completed  |
| B. SUBCONTRACTOR OWNERSHIP | Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. | New |
| C. INDIVIDUAL RELATIONSHIPS | Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling. | New |
| D. MANAGING EMPLOYEES | Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity. | New |
| E. BUSINESS RELATIONSHIPS | Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity. | New |
| F. CONVICTIONS OF CRIMINAL OFFENSE | Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Childrens Health Insurance Program or the Title XX services since the inception of these programs. | New |

Disclosure B is regarding Subcontractor Ownership and Control. Indicate all persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity/applicant has direct or indirect ownership of 5% or more.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “Add” button and the panel will update.

Disclosures Panel – Subcontractor Ownership and Control Disclosure B - Questions

Disclosure B Information - Subcontractor Ownership and Control

List the name, address, federal employer identification number (EIN) or Social Security Number (SSN) and date of birth (DOB) of each person or entity with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. If "None", select "No" to indicate that subcontractor ownership/control interest does not apply.

1. ***Is there any person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership as indicated above?**
 Yes No

***% Interest:**

***Full Name:**

***Street Address:**

***City:**

***State:**

***Zip:**

***SSN/EIN:**

2. ***Is the entity entered above an individual?**
 Yes No

***Date of Birth:**

Continue to add entities as applicable. When all Subcontractor Ownership and Control information is entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

Disclosure C is regarding Individual Relationships. Indicate any individuals mentioned in Disclosure A and Disclosure B that are related to one another as a spouse, parent, child or sibling.

A “Yes” answer will open an additional section for the required information to be entered.

Disclosures Panel – Individual Relationships Disclosure C – Questions

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| # | Disclosure Name | Action |
|--|--------------------|--------|
| <input type="checkbox"/> | Click to collapse. | |
| Disclosure C Information - Individual Relationships | | |
| <p>List the name, social security number, date of birth, and relationship for any of the persons mentioned in Disclosures A and B that are related to one another as a spouse, parent, child, or sibling. If no person meets the criteria, select "No".</p> <p>1. *Are there any persons mentioned in Disclosure A and B related to one another as outlined above? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Full Name of Person 1: <input type="text"/></p> <p>*SSN: <input type="text"/></p> <p>*Date of Birth: <input type="text"/></p> <p>*Relationship: <input type="text"/></p> <p>*Full Name of Person 2: <input type="text"/></p> <p>*SSN: <input type="text"/></p> <p style="text-align: center;"><input type="button" value="Add"/></p> | | |

When the information is completed, click the “Add” button and the panel will update.

Continue to add individuals as applicable. When all Individual Relationships are entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

Disclosure D is regarding Managing Individuals. Indicate any individuals that hold a position of managing employee within the disclosing entity/applicant.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “Add” button and the panel will update.

Disclosures Panel – Managing Individuals Disclosure D – Questions

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| # | Disclosure Name | Action |
|--------------------------|--------------------|--------|
| <input type="checkbox"/> | Click to collapse. | |

Disclosure D Information - Managing Individuals

List any person who holds a position of managing employee within the disclosing entity, fiscal agent or managed care entity. If no person meets the criteria, select "No".

1. *Is there any person who holds a position of managing employee as outlined above?
 Yes No

*First Name:

Middle Initial:

*Last Name:

*SSN:

*Date of Birth:

*Street Address:

*City:

*State:

*Zip:

Continue to add individuals as applicable. When all Managing Individuals are entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

Disclosure E is regarding Business Relationships. Indicate any persons or entity (identified in Disclosure A) that has an ownership or controlling interest of 5% or greater in any other provider, fiscal agent or managed care entity.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “Add” button and the panel will update.

Disclosures Panel – Business Relationships Disclosure E– Questions

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| # | Disclosure Name | Action |
|---|--------------------|--------|
| <input type="checkbox"/> | Click to collapse. | |
| Disclosure E Information - Business Relationships | | |
| <p>List any person or entity (identified in Disclosure A) that has an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity. If no person or entity meets the criteria above, select "No".</p> <p>1. *Is there any individual with an ownership or control interest as outlined above? <input checked="" type="radio"/> Yes <input type="radio"/> No % Interest: <input type="text"/> *Full Name of Provider: <input type="text"/> SSN: <input type="text"/> Date of Birth: <input type="text"/> *Full Name Other Provider: <input type="text"/> SSN/EIN: <input type="text"/></p> <p>2. *Is there any business, organization or corporation with an ownership or control interest as outlined above? <input checked="" type="radio"/> Yes <input type="radio"/> No % Interest: <input type="text"/> *Full Name of Provider: <input type="text"/> EIN: <input type="text"/> *Full Name Other Provider: <input type="text"/> SSN/EIN: <input type="text"/></p> <p style="text-align: center;"><input type="button" value="Add"/></p> | | |

Continue to add entities as applicable. When all Business Relationships are entered, click on the "Submit" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed".

Disclosure F is regarding Convictions. Indicate any persons with ownership or controlling interest in, or that is an agent or managing employee of the applicant who has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.

Disclosures Panel – Conviction Disclosure F – Questions

Click "+" to view or update the details in a row. Click "-" to collapse the row. To add a new row, enter all the required fields and click the "Add" button. Click "Remove" to remove the entire row.

| # | Disclosure Name | Action |
|--|-----------------|---|
| <input type="checkbox"/> Click to collapse. | | |
| Disclosure F Information - Conviction Disclosure | | |
| <p>List any person (individual or corporation) who has an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of:</p> <ul style="list-style-type: none"> ▪ a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHP+ or the Title XX services since the inception of these programs; ▪ neglect or abuse of a patient, in connection with the delivery of a health care item or service; ▪ fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than Medicare and a State health care program) operated by, or financed in whole or in part, by any Federal, State or local government agency; ▪ an offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance. <p>1. *Is there any person who has been convicted of a criminal offense as outlined above? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Full Name: <input type="text"/></p> <p>*SSN/EIN: <input type="text"/></p> <p>*Offense: <input type="text"/></p> <p>*Conviction Date: <input type="text"/> <input type="button" value="📅"/></p> <p>*Jurisdiction: <input type="text"/></p> <p>2. *Is the entity entered above an individual? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Date of Birth: <input type="text"/> <input type="button" value="📅"/></p> <p style="text-align: center;"><input type="button" value="Add"/></p> | | |
| | | <input type="button" value="Submit"/> <input type="button" value="Cancel"/> |

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “Add” button and the panel will update.

Continue to add entities as applicable. When all Convictions are entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

When all questions have been completed within the Disclosures panel, select “Continue”, “Finish Later” or “Cancel”.

Disclosures Panel – Completed

| Available Enrollment Disclosures | | |
|---|--|-----------|
| Click the disclosure name to open the disclosure for editing. After completing the disclosure, select "Add". When you have completed the disclosure, click "Submit" to return to the main Disclosures page. All Disclosures must be completed to Continue . | | |
| Disclosure Name | Description | Status |
| A. OWNERSHIP OR CONTROL INTEREST | Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more. | Completed |
| B. SUBCONTRACTOR OWNERSHIP | Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. | Completed |
| C. INDIVIDUAL RELATIONSHIPS | Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling. | Completed |
| D. MANAGING EMPLOYEES | Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity. | Completed |
| E. BUSINESS RELATIONSHIPS | Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity. | Completed |
| F. CONVICTIONS OF CRIMINAL OFFENSE | Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Childrens Health Insurance Program or the Title XX services since the inception of these programs. | Completed |
| Continue Finish Later Cancel | | |

Fingerprinting Panel

If the provider's Revalidation Risk Level is 'High', the below panel will be displayed, and fingerprints are required for each individual owner that is listed with an ownership of 5% or more. The Provider's data is pulled from the **Provider Identification** panel and the **Request Information** panel in the application. If an Owner and Provider have the same Tax ID, then the Owner with the matching TAX ID will not display. Owner information will be populated by the individual owner information that is entered on the Disclosures panel in the application. For providers that are business entities, all owners with 5% or more interest in the business will be displayed with a status indicating any individuals that need to submit fingerprints at this time.

Alert: Fingerprinting and Criminal Background Check ?

- All high-risk Providers and any Owner with 5% or more interest in the Provider, must complete a Fingerprint Criminal Background Check as part of enhanced enrollment screening provisions contained in Section 6401 of Affordable Care Act (ACA).

Please click [+] for EACH person identified below, and complete the answers before submitting.

| | Type | Name | Tax ID | Status | Pass/Fail |
|--------------------------|----------|-------------|-----------|-------------|---------------|
| <input type="checkbox"/> | Provider | ABC Company | 123456789 | Not Noticed | Not Completed |
| <input type="checkbox"/> | Owner | John Doe | 123456789 | Not Noticed | Not Completed |

If an Owner has **not** completed their Fingerprinting and Criminal Background Check (for either **MEDICARE or MEDICAID**), please follow the instructions on this panel to have fingerprints submitted within 30 calendar days of the submission of the Revalidation application. Please review the Fingerprinting FAQ on the [Provider FAQ Central web page](#) and select the Fingerprinting drop-down section.

Event: Fingerprinting and Criminal Background Check ?

- All high-risk Providers and any Owner with 5% or more interest in the Provider, must complete a Fingerprint Criminal Background Check as part of enhanced enrollment screening provisions contained in Section 6401 of Affordable Care Act (ACA).

Please click [+] for EACH person identified below, and complete the answers before submitting.

| | Type | Name | Tax ID | Status | Pass/Fail |
|--|----------|-------------|-----------|-------------|---------------|
| <input type="checkbox"/> | Provider | ABC Company | 123456789 | Not Noticed | Not Completed |
| This is a business entity and does not require fingerprints, please complete Fingerprinting for all individual owners listed | | | | | |
| <input type="checkbox"/> | Owner | John Doe | 123456789 | Not Noticed | Not Completed |

***Have you completed Fingerprinting for MEDICARE?** Yes No
***Have you completed Fingerprinting for MEDICAID in any State?** Yes No

Fingerprints for all persons listed above must be submitted to the department within 30 days of the date of Application or Revalidation of a high-risk provider. Failure to respond within 30 days of submission of the application could result in the denial of the application. Individuals may NOT fingerprint themselves; fingerprints MUST be obtained from a State of Colorado approved CABS service provider. Please visit the [Colorado Bureau of Investigation](#) web page for more information.

Save
Reset
Cancel

Continue
Finish Later
Cancel

If an Owner has completed their Fingerprinting and Criminal Background Check (for either **MEDICARE** or **MEDICAID**), mark “Yes” next to the appropriate selection. If marked “Yes”, the panel will update and request confirmation of which state the fingerprinting was completed in. Then check the box next to the acknowledgement statement.

Section: Fingerprinting and Criminal Background Check ?

- All high-risk Providers and any Owner with 5% or more interest in the Provider, must complete a Fingerprint Criminal Background Check as part of enhanced enrollment screening provisions contained in Section 6401 of Affordable Care Act (ACA).

Please click [+] for EACH person identified below, and complete the answers before submitting.

| | Type | Name | Tax ID | Status | Pass/Fail |
|--|----------|-------------|-----------|-------------|---------------|
| <input type="checkbox"/> | Provider | ABC Company | 123456789 | Not Noticed | Not Completed |
| This is a business entity and does not require fingerprints, please complete Fingerprinting for all individual owners listed | | | | | |
| <input type="checkbox"/> | Owner | John Doe | 123456789 | Not Noticed | Not Completed |

***Have you completed Fingerprinting for MEDICARE?** Yes No

***Have you completed Fingerprinting for MEDICAID in any State?** Yes No

***What state, including CO, was fingerprinting completed in? (if fingerprinting is complete for multiple states, enter the most recent state)**

***** By submitting this information I recognize that the Department will validate fingerprinting results with the entity reported above. If sufficient documentation to support the information submitted cannot be provided to the Department, I acknowledge that I may still need to submit Fingerprints to the Department to be in compliance with the ACA. (Box must be checked to save this information for each person listed).

Click "Save" once completed for **each Owner** and then click "Continue" to the next section.

Once the application is submitted, Providers and owners requiring fingerprinting will be given specific instructions on how to proceed.

Attachments and Fees Panel



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Home > [Provider Revalidation](#) > Revalidation Attachments And Fees
Tuesday 03/31/2020 06:05 PM MST

| | | |
|---------------------------------------|---|--|
| Provider Name Medical Provider | Provider ID Providers - 1234567891 (NPI) | Location 000000000 - Medical Provider |
| Taxonomy 363LF0000X | | |

Provider Revalidation: Attachments And Fees

[Welcome](#)

[Request Information](#)

[Specialties](#)

[Addresses](#)

[Provider Identification](#)

[Languages](#)

[Other Information](#)

[Disclosures](#)

Attachments and Fees

[Agreement](#)

[Summary](#)

Supporting Documentation

Please submit electronic copies of all documentation required for the selected Provider Type and Specialty. A list of required documents can be found on this website: Colorado.gov/HCPF/Information-Provider-Type. If a hardship exemption is being requested in lieu of the application fee, please upload the letter and supporting documentation here as well.

Submit as Attachment: [Completed Proof of Lawful Presence](#) (if applicable)

Submit as Attachment: [Completed Supervising Physician Signature Form](#) (if applicable)

Submit as Attachment: License (if applicable)

* Indicates a required field.

Revalidation Attachments

To add an attachment, complete the required fields and click the **Add** button. Attachments cannot be saved for later. If you are not intending to submit the application at this time, it is suggested to wait to upload any attachments until you are ready to submit.

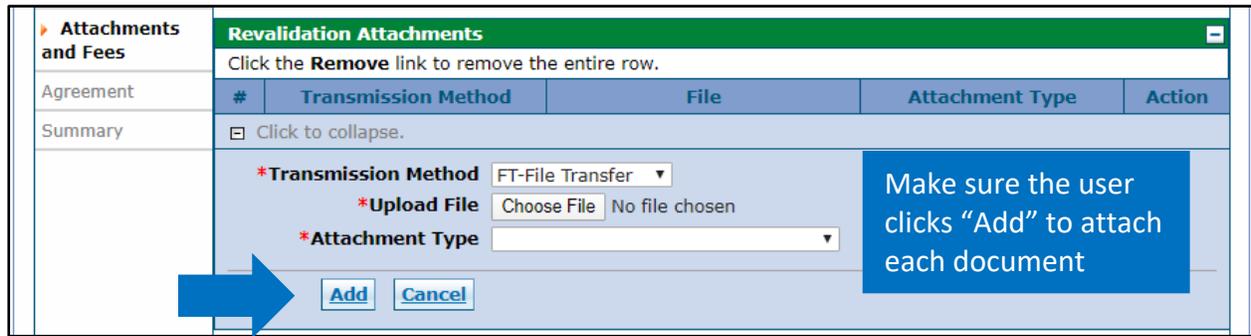
Note: if you choose to "Upload" attachments by "File Transfer", a maximum of 5 MBs of information can be uploaded. The allowable file types are: bmp, doc, docx, gif, jpg, jpeg, pdf, ppt, tif, tiff, txt, xls, xlsx, csv.

Click the **Remove** link to remove the entire row.

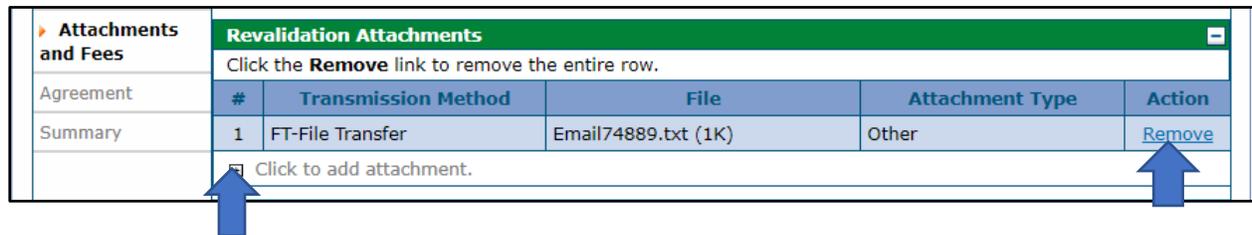
| # | Transmission Method | File | Attachment Type | Action |
|---|---------------------|------|-----------------|--------|
| <input type="checkbox"/> Click to collapse. | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>*Transmission Method FT-File Transfer ▾</p> <p>*Upload File <input type="button" value="Choose File"/> No file chosen</p> <p>*Attachment Type <input type="text" value=""/></p> </div> <div style="width: 30%; text-align: center;"> <p><input type="button" value="Add"/> <input type="button" value="Cancel"/></p> </div> </div> | | | | |
| Application Fee | | | | |
| <div style="border: 1px solid #ccc; padding: 5px; display: inline-block;"> No Application Fee Required </div> | | | | |
| <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> | | | | |

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Attachments Section



Select the '+' sign to add each attachment as needed. Select the 'Remove' link to remove an attachment. Select 'Continue', 'Finish Later', or 'Cancel' once all attachments have been added.



Required attachments may be submitted electronically on this panel. Please note that attachments sent by mail, email or fax cannot be accepted. These must be added to the attachments and fees page of the Revalidation application.

Not all documents listed under Supporting Documentation may apply to revalidation.

If any of the following information was added or updated in the Revalidation application, then a current copy is required to be included:

- Licenses
- Certifications
- Malpractice/General Liability insurance (nursing facilities only)
- Institutional bed information – License required

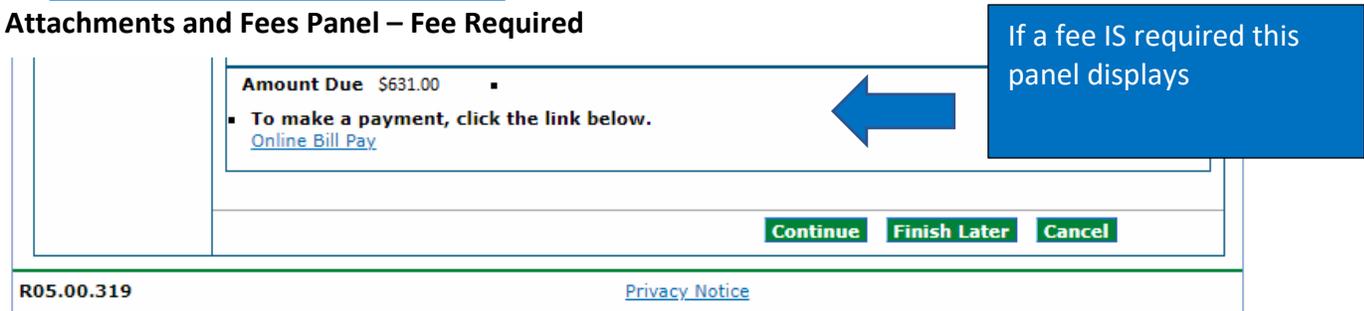
Application Fee Section

The application fee is required to be paid during revalidation. The Application Fee questions as shown in the panel below will only be displayed when applicable. If the service location has enrolled or revalidated with Medicare or another state’s Medicaid program in the last 5 years, and paid an application fee, the application fee may not be required for revalidation. A copy of the receipt indicating payment must be uploaded on this page in the attachments section with a selection type of “Other”.

Attachments and Fees Panel – No Fee Required



Attachments and Fees Panel – Fee Required



Financial Hardship – If the user is requesting a waiver for financial hardship, include a letter describing the financial hardship and why the hardship justifies an exception, as well as any additional supporting documentation that the user believes may aid the Department and CMS (Centers for Medicare & Medicaid Services) in the determination. If the user chooses to apply for an application fee waiver, the revalidation will be delayed while a determination is made. The letter and supporting documentation must be uploaded on this page in the attachments section with a selection type of “Other”.

If it is determined that an application fee is due, click the “Online Bill Pay” link, and a payment form will open in a pop-up window:

Online Bill Pay

Welcome to the Online Bill Pay Process
Please complete each section of the online bill pay process to make a one-time payment for your Colorado Medicaid bill.

The following forms of payment are accepted:



Account Information

Personal Business

Business Name

Address

City **State** **Zip Code**

Phone Number

Payment Information

***Payment Method**

***Card Number** ***Verification Code**

***Card Expiration Date** ***Billing Address Zip Code**

Payment Amount \$631.00

A credit/debit card processing fee of 2.95% or e-check processing fee of \$2.50 will be added during payment authorization.

Note: A processing fee of 2.95% is charged for a debit/credit card payment, and a processing fee of \$2.50 is charged for an e-check.

Enter email address below to receive a confirmation email.

Email Address **Email Address Confirmation**

Authorize Payment

Please verify your payment above and make any necessary changes. When verification is complete, click the "Authorize Payment" button below to submit your payment.

Your payment will not be processed until you click the "Authorize Payment" button below. Only click once to avoid duplicate payments. Once your payment has processed, you will receive a confirmation number that you can print for your records. Click the "Cancel" button below to stop this payment process and exit. Do not use your browser Back button.

Authorize Payment
Cancel

Agreement Panel

Below is the Agreement panel. The terms of revalidation are stated here. Acceptance of these terms is required in order to submit the Revalidation application. Failure to accept these terms means that no Revalidation application is retained or submitted. Click the link to the “Provider Participation Agreement” and read the agreement in order to complete the page.



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[Home](#) > [Provider Revalidation](#) > Revalidation Agreement Tuesday 03/31/2020 06:39 PM MST

Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 000000000 - Medical Provider

Taxonomy 363LF0000X

Provider Revalidation: Agreement ?

| | |
|---|---|
| Welcome | Instructions |
| Request Information | The terms of revalidation are stated below. You must accept these terms in order to submit the revalidation application. Failure to accept these terms means that no revalidation application is retained or submitted. |
| Specialties | Access the summary of revalidation link to review all data that has been entered into the revalidation application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the revalidation application can be reviewed again. |
| Addresses | |
| Provider Identification | Once the application is submitted and confirmed, a tracking number will be assigned. Please print a copy of your tracking number and application for your records. |
| Languages | |
| Other Information | |
| Disclosures | Terms of Agreement |
| Attachments and Fees | <p>Provider Name Medical Provider</p> <p>Address 648 FIRST DENVER Colorado, 87542</p> <p>Tax II 12345678</p> <p>NP: 1234567891</p> <p>Contact Name John Doe</p> <p>Contact Email johndoe@johndoe.com</p> |
| Agreement | NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE. |
| Summary | Please read and print for your records the Provider Participation Agreement. The Provider Participation Agreement applies to all Programs. |
| | Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Participation Agreement has been read. |

Read and Print: [Provider Participation Agreement](#) 

(You must review the Provider Participation Agreement prior to signing below)

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

*I accept I understand that my electronic signature is equivalent to written signature.

***Your Signature**

(Entering your name in the box to the right will constitute your electronic signature.)

Suffix

Submission Date 03/31/2020

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Once complete, a checkmark will then appear next to it:

Terms of Agreement

Provider Name Medicaid Provider
Address 1234 Your Street
 Denver
 Colorado, 80202
Tax ID 123456789
NPI
Contact Name Firstname Lastname
Contact Email MedicaidProvider@health.com

NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE.

Please read and print for your records the Provider Participation Agreement. The Provider Participation Agreement applies to all Programs.

Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Participation Agreement has been read.

Read and Print: [Provider Participation Agreement](#) 

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.

*I accept I understand that my electronic signature is equivalent to written signature.

***Your Signature**

(Entering your name in the box to the right will constitute your electronic signature.)

Suffix

Submission Date 07/20/2015

If the user does not print the provider participation agreement at this time, they may view a copy of this agreement on the [Provider Forms web page](#).

Enter the Provider name as the electronic signature and click in the “I accept” box in order to complete the page. The “Review” button will then become active.

| | |
|-------------------|--|
| | <p style="text-align: center;">Contact Name John Doe Contact Email johndoe@johndoe.com</p> <p>NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE.</p> <p>Please read and print for your records the Provider Participation Agreement. The Provider Participation Agreement applies to all Programs.</p> <p>Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Participation Agreement has been read.</p> <p>Read and Print: Provider Participation Agreement </p> <p>(You must review the Provider Participation Agreement prior to signing below)</p> <p>You will be submitting the Provider Revalidation application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.</p> <p>*I accept <input checked="" type="checkbox"/> I understand that my electronic signature is equivalent to written signature.</p> <p>*Your Signature <input type="text" value="Medicaid Provider"/></p> <p>(Entering your name in the box to the right will constitute your electronic signature.)</p> <p>Suffix <input type="text"/></p> <p>Submission Date 03/13/2020</p> <p style="text-align: right;">Review Finish Later Cancel</p> |
| R05.00.317 | Privacy Notice  |

Summary Panel

This panel will show the Revalidation application in its entirety. At this point the user should review all information that has been entered for accuracy.



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[Home](#) > [Provider Revalidation](#) > Revalidation Summary Tuesday 03/31/2020 06:58 PM MST

Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 000000000 - Medical Provider

Taxonomy 363LF0000X

Print Preview

Provider Revalidation: Summary
?

Welcome

Request Information

Specialties

Addresses

Provider Identification

Languages

Other Information

Disclosures

Attachments and Fees

Agreement

▶ Summary

Request Information

Revalidation Effective Date 03/31/2020

Enrollment Type Ordering, Prescribing, Referring **Provider Type** Physician

Provider Federal Tax Identification Number (TIN) 123456

Effective Date 02/14/2020 **End Date** 12/31/2299 **Fiscal End Date** _

NPI 1234567 **MCD**

NPI Zip + 4 87542-1457 **Taxonomy** 363LF000X

Contact Name John Doe

Contact Phone 1-123-456-7890 **Ext** _

Contact Email johndoe@johndoe.com

Preferred Method of Communication Email

Email For Provider Publications johndoe@johndoe.com

Addresses Expand All | Collapse All

| | Address Type | Address | City | State |
|--------------------------|------------------|-----------|--------|----------|
| <input type="checkbox"/> | Service Location | 648 FIRST | DENVER | Colorado |
| <input type="checkbox"/> | Billing | 648 FIRST | DENVER | Colorado |
| <input type="checkbox"/> | Mailing | 648 FIRST | DENVER | Colorado |

| Specialties | | |
|---|--|---|
| <input checked="" type="checkbox"/> Specialty Physician | Taxonomy Preventive Medicine - Medical Toxicology | Effective Date 01/01/2019 - 12/31/2299 |
| Provider Identification | | |
| Last Name Doe | First Name John | Middle _ |
| Gender Female | Suffix _ | Birth Date 01/01/1980 |
| Medicare # _ | Effective Date _ | Medicare Type _ |
| Languages | | |
| No Languages exist for this application | | |
| Other Information | | |
| Malpractice/General Liability Insurance | | |
| No Malpractice/General Liability Insurance exist for this application | | |
| Certification | | |
| No Certification exist for this application | | |
| Medicaid Participation | | |
| <ol style="list-style-type: none"> Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)? No Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)? No Have you ever been denied enrollment for cause in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP in Colorado or of any other state(s)? No Has your enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s) ever been terminated or revoked for cause? No | | |

| | | |
|--|--|---------------|
| | <p>5. Have you ever been excluded from participation in Medicare, Medicaid and all other Federal health care programs by the Office of the Inspector General, U.S. Department of Health and Human Services? No</p> <p>6. Have you ever been excluded from participation in federal procurement? No</p> <p>7. Do you hold all licenses and certifications as required based on your provider type? Yes</p> <p>8. Is this license expired, or subject to conditions or restrictions? No</p> <p>9. Have you ever been subject to a payment suspension based on a credible allegation of fraud? No</p> <p>10. Do you currently have an outstanding overpayment of \$1,500 or more that is over 30 days past due, you have not entered into a payment plan for, and is not currently the subject of an appeal? No</p> | |
| Website Address _ | | |
| Addendums | | |
| Disclosures | | |
| Disclosure Name | Description | Status |
| A. OWNERSHIP OR CONTROL INTEREST | Persons (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent or managed care entity having direct or indirect ownership of 5% or more. | Completed |
| B. SUBCONTRACTOR OWNERSHIP | Persons or entities with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more. | Completed |
| C. INDIVIDUAL RELATIONSHIPS | Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling. | Completed |
| D. MANAGING EMPLOYEES | Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity. | Completed |

| | | |
|--|--|------------------|
| <p><u>E. BUSINESS RELATIONSHIPS</u></p> | <p>Persons, businesses, organizations or corporations with an ownership or control interest (identified in Disclosure A) that have an ownership or controlling interest of 5% or more in any other provider, fiscal agent or managed care entity.</p> | <p>Completed</p> |
| <p><u>F. CONVICTIONS OF CRIMINAL OFFENSE</u></p> | <p>Persons who have an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Children's Health Insurance Program or the Title XX services since the inception of these programs.</p> | <p>Completed</p> |
| <p>Supporting Documentation</p> | | |
| <p>Please submit electronic copies of all documentation required for the selected Provider Type and Specialty. A list of required documents can be found on this website: Colorado.gov/HCPF/Information-Provider-Type. If a hardship exemption is being requested in lieu of the application fee, please upload the letter and supporting documentation here as well.</p> | | |
| <p>Submit as Attachment: Completed Proof of Lawful Presence (if applicable)</p> | | |
| <p>Submit as Attachment: Completed Supervising Physician Signature Form (if applicable)</p> | | |
| <p>Submit as Attachment: License (if applicable)</p> | | |
| <p>No Revalidation Attachments exist for this application</p> | | |
| <p>Application Fee</p> | | |
| <p>No Application Fee Required</p> | | |
| <p>Terms of Agreement</p> | | |
| <p>NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE.</p> | | |
| <p>Please read and print for your records the Provider Participation Agreement. The Provider Participation Agreement applies to all Programs.</p> | | |
| <p>Please note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until the Provider Participation Agreement has been read.</p> | | |
| <p>Read and Print: Provider Participation Agreement</p> | | |
| <p>(You must review the Provider Participation Agreement prior to signing below)</p> | | |

| | |
|------------|---|
| | <p>You will be submitting the Provider Revalidation application electronically. Therefore, your signature on this application will be electronic. By submitting this application electronically, you acknowledge that you understand that your electronic signature is binding to the same extent as your written signature.</p> <p>I understand that my electronic signature is equivalent to written signature.</p> <p style="text-align: center;">Your Signature first last (Entering your name in the box to the right will constitute your electronic signature.) Suffix _ Agreement Date 03/31/2020</p> <p style="background-color: #0070C0; color: white; text-align: center;">Instructions for Summary Page</p> <p>If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields. Once you have reviewed the contents of this application, select 'Confirm' to submit the enrollment for processing. Please print a copy of this summary for your records.</p> <p style="text-align: center;"> <input type="button" value="Print Preview"/> <input type="button" value="Submit"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </p> |
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Print Preview – Select this button to print a copy of the Revalidation application. This will be the only opportunity to print a copy of the Revalidation application.

Submit – Select this button to submit the Revalidation application for review.

Finish Later – Select this button to save the information and finish the application later.

Cancel – Select this button to log out of the application without saving the information.

When the “Submit” button is selected, the user will be asked if they have printed a copy of this application for their records. If the user has already printed a copy, or does not wish to print a copy, click “OK”. If the user would like to print a copy and has not done so yet, click “Cancel” to return to the application to print a copy.



Once the “OK” button has been selected, the provider will be assigned a tracking number to the Revalidation application:

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[Home](#) > [Provider Revalidation](#) > [Revalidation Summary](#) > Revalidation Tracking Information Monday 04/06/2020 04:10 PM MST

Provider Name Medical Provider **Provider ID** Providers - 1234567891 (NPI) **Location** 0000000000 - Medical Provider
Taxonomy 363LF0000X

[Print Preview](#)

Provider Revalidation: Tracking Information

Your revalidation application has been submitted.
Your revalidation application has been assigned the following tracking number: 223712

Please retain the tracking number for your records. The tracking number will be used to revise your submitted revalidation at a later date, if needed.

A confirmation email has also been sent to the following contact person's email, designated in the revalidation application:
provider@provider.com.

Thank you for submitting an application to revalidate your current Medicaid enrollment.

Revalidation Application Processing Times:
Current revalidation processing times average 4-6 weeks. This turnaround time will be shorter if your revalidation application was submitted completely and correctly. Likewise, your revalidation application turnaround time may be longer if it requires correction or additional documentation. If your provider type is classified as moderate or high risk, you should expect additional processing time for an unannounced revalidation site visit (typically 5-8 additional business days).
You will be updated, via email, as your revalidation application moves through the process. **Please be aware you are not able to access your revalidation application after you submit it, unless your application requires correction.**

[Exit](#)

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Select the “Exit” button to return to the **Welcome** panel.

For additional support, providers may contact the Department’s fiscal agent for Health First Colorado by calling the Provider Services Call Center at 1-844-235-2387.

Providers may also visit the [For Our Providers](#) web page for additional resources.

Resume Revalidation

If the user was unable to complete the revalidation process and elected to save the work, the process can be resumed by logging in to the provider web portal and selecting the Revalidation link. The provider will be brought to the Revalidation application.

If the application was completed, but the user received a Return to Provider (RTP) email from fiscal agent stating additional or corrected information is needed, access the application using the same link.

User Details

Welcome John Doe

- My Profile
- Manage Accounts

Provider

Name John Doe

Provider ID 123456789

Location ID 1234567

Revalidation Date 4/1/2020

- Provider Maintenance
- EFT/ERA (835) Enrollment
- Disenroll
- Revalidation**

Welcome Health Care Professional!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Provider Portal News

You are connected to the Model Office System

- Contact Us
- Notify Me
- Alerts
- Secure Correspondence

Unless the Revalidation application is returned to a provider (RTP) for updates or corrections, no changes may be made to the information entered once the application is submitted.

Revalidation Status

If the application has been submitted for review, selecting the “Revalidation” link will bring the provider to the Provider Revalidation Status panel:

| | | |
|--|---|---|
| Home > Provider Revalidation > Enrollment Status | | Friday 03/13/2020 02:19 PM MST |
| Provider Name Medical Provider | Provider ID Providers - 1234567891 (NPI) | Location 0000000000 - Medical Provider |
| Taxonomy 363LF0000X | | |
| Provider Revalidation - Status | | Back to My Home ? |
| Enter your assigned tracking number to verify the current status of your revalidation application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Revalidation. | | |
| * Indicates a required field. | | |
| Tracking Number 123456 | | |
| <input type="button" value="Search"/> <input type="button" value="Cancel"/> | | |
| Provider Revalidation - Summary | | |
| Below is the status of your provider revalidation application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment. | | |
| Tracking Number 123456 | | |
| Date Submitted 03/13/2020 | | |
| Status Under Review | | |
| Status Date 03/13/2020 | | |

Even if there are notes here indicating the application needs to be returned to the provider, the user **WILL NOT** be able to access the application to make corrections until this status reads “Returned to Provider for Additional Information”, “Returned to Provider for Additional Authorization(s)” or “Returned to Provider for Missing Documentation”.

Once the Revalidation application is returned to the provider, a notification email is sent to the contact email address entered.

To make the required corrections the user will need to log in to the provider web portal and select the revalidation link on the Welcome page. If the status indicates that corrections are needed, select the “Revise Revalidation Application” link as shown below.

This link only displays when the application is returned for corrections.

| | | | | |
|----------------------|-----------------------------|------------------------|---------------------------------|---------------------------|
| Home | Eligibility | Claims | Care Management | Resources |
|----------------------|-----------------------------|------------------------|---------------------------------|---------------------------|

[Home](#) > [Provider Revalidation](#) > Enrollment Status Thursday 07/11/2019 12:24 PM MST

| | | |
|---------------------------------------|---|---|
| Provider Name Medical Provider | Provider ID Providers - 1234567891 (NPI) | Location 0000000000 - Medical Provider |
| Taxonomy 363LF0000X | | |

| | |
|---------------------------------------|---------------------------------|
| Provider Revalidation - Status | Back to My Home |
|---------------------------------------|---------------------------------|

Enter your assigned tracking number to verify the current status of your revalidation application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Revalidation.

* Indicates a required field.

***Tracking Number**

| |
|--|
| Provider Revalidation - Summary |
|--|

Below is the status of your provider revalidation application. For any further queries, please refer to the [Provider Resources](#) web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Revalidation.

Tracking Number 123456
Date Submitted 07/11/2019
Status Returned to provider for Additional Information
Status Date 07/11/2019
Reason Instructions-RTP:Check address mismatch
Notes 07/11/2019: Please refer to the instructions provided in the RTP Letter that is emailed to you to determine what needs to be corrected and resubmitted in your application.

[Revise Revalidation Application](#)

The user will then be brought to the Revalidation application to make the necessary corrections indicated in the letter and resubmit the Revalidation application.

Site Visits

Per federal requirement 42 CFR 455.432, site visits are required for providers who are designated as “moderate” or “high” categorical risks.

The purpose is to verify that the information submitted to the Department of Health Care Policy & Financing (the Department) is accurate and to determine compliance with federal and state enrollment requirements. If the provider type falls into one of these risk categories, the user will be contacted for the required site visit. A representative will visit the service location to verify certain aspects of the revalidation. Providers that refuse a site visit may be excluded from participation.

For further information about risk categories by provider type, please refer to the risk levels on the Information by [Provider Type web page](#).

Provider Revalidation Notifications

The provider will receive several email notifications during the revalidation process which will be sent to the contact email address entered in the Contact Information section of the Revalidation application.

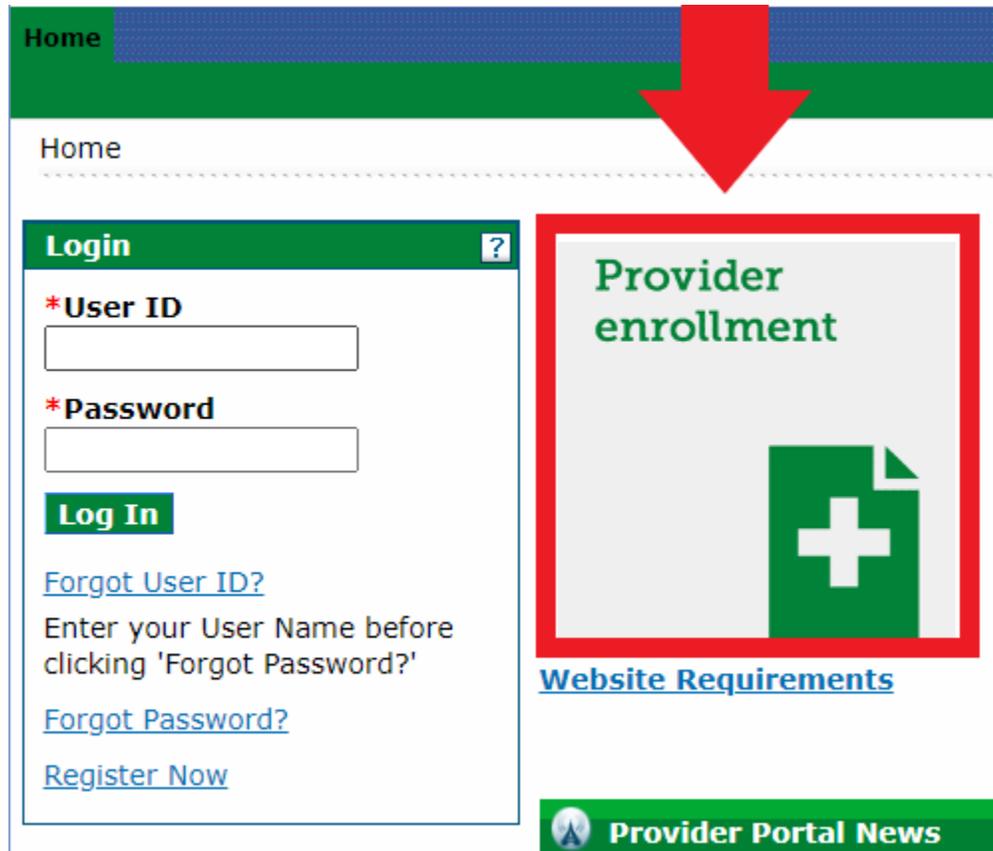
Fiscal agent reviewers may also use this information to reach out directly with questions about the Revalidation application.

- During the revalidation review process, if additional information and/or missing documentation is needed, a notification email will be sent to the email address entered in the contact information. The applicant will then be able to return to the Revalidation application by logging in to the provider web portal and selecting the Revalidation link. Once this is completed, the fiscal agent will be notified of the update and will continue processing.
- Once the application has been reviewed, an email notification will be sent to the address entered in the contact information advising the applicant of the outcome.
 - If the Revalidation application is approved, the user will be advised of the approval.
 - If the Revalidation application is rejected, the user will be advised of the reason. (See **File a Grievance** section for more information).

File a Grievance

If the Revalidation application is rejected or denied, the user has the option to submit a new Revalidation ATN or they may file a grievance to have the application re-opened for processing. If the Revalidation ATN has been denied, and the revalidation link is selected, this will initiate a new Revalidation application. To have the denied application re-opened for processing the user may follow the below steps to submit a grievance.

1. Go to [Provider Enrollment Portal Home page](#) .
2. Select this box.



The screenshot shows the top navigation bar with a 'Home' link. Below it is a 'Home' breadcrumb. The main content area is divided into two columns. The left column contains a 'Login' form with fields for '*User ID' and '*Password', a 'Log In' button, and links for 'Forgot User ID?' and 'Forgot Password?'. The right column features a red-bordered box with the text 'Provider enrollment' and a green document icon with a white cross. Below this box is a link for 'Website Requirements' and a green button for 'Provider Portal News'.

3. Select the Enrollment Status link.

Provider Enrollment

[Enrollment Application](#)
Initiate a new provider enrollment application.

[Resume Enrollment](#)
Resume an existing enrollment application that has not been submitted.

Enrollment Status
Check the current status of an enrollment application.

4. Enter the Application Tracking Number (ATN) and Tax ID number, then click the Search button.

Provider Enrollment - Status [Back to My Home](#) ?

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For any further queries, please refer to the Provider Resources web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

* Indicates a required field.

***Tracking Number** ***Tax ID Number**

[Search](#) [Cancel](#)

5. Scroll to the bottom of the page and select link 'Click here to submit a grievance'.

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For any further queries, please refer to the [Provider Resources](#) web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

Tracking Number 1234567
Date Submitted 04/06/2020
Status Denied
Status Date 04/06/2020
Reason Eligibility error-DEN: Duplicate Application
Notes 04/06/2020:
Reason _
Notes 04/06/2020: Deny to test grievance process.
Reason _
Notes 04/06/2020: Deny to test grievance process.

If you disagree with this outcome and want to appeal this decision [Click here to submit a grievance](#)

6. Enter the reason for disagreeing with the decision and click the Submit button.

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For any further queries, please refer to the [Provider Resources](#) web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

Tracking Number 123456
Date Submitted 04/06/2020
Status Denied
Status Date 04/06/2020

Provider Enrollment - Grievance

Enrollment Grievance for the following Provider:

Provider Name Medical Provider
Address 123 ABC Ave

—

* Indicates a required field.

Select one or more reasons for Grievance.

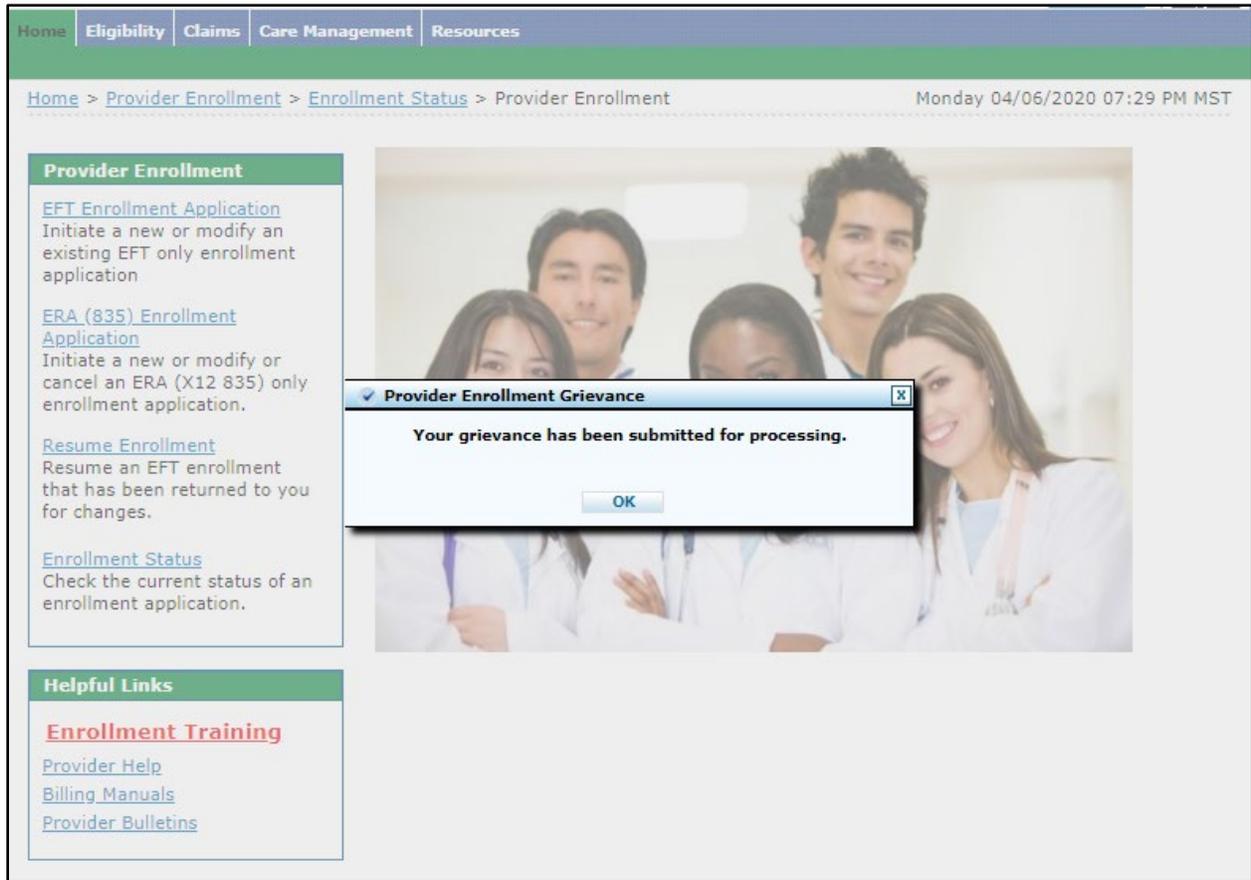
Grievance Reasons

- DEA number is expired
- DEA verification returned adverse results
- State Determination Verification returned adverse results
- Fingerprint/Background Assessment was unsuccessful
- LEIE (OIG) Verification returned adverse results
- License or Certification has an adverse status
- License or Certification is expired
- Medicaid / Medicare number is not enrolled
- Medicaid / Medicare number is deactivated
- NPI is deactivated or invalid
- SAM (formerly EPLS) Verification returned adverse results
- The Social Security Administration Death Master List has reported this Name, SSN, and DOB as being a deceased person
- Site Visit Inspection was unsuccessful

NOTE: Only the first 500 characters will be saved with this Grievance Request.

*Comments

7. The grievance has been filed.



The status will also change to reflect this.

Provider Enrollment - Status [Back to My Home](#)

Enter your assigned tracking number and Tax ID to verify the current status of your enrollment application. For any further queries, please refer to the [Provider Resources](#) web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

* Indicates a required field.

***Tracking Number** ***Tax ID Number**

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For any further queries, please refer to the [Provider Resources](#) web page for additional information such as FAQs, Fact Sheets, and other communication regarding Provider Enrollment.

Tracking Number 123456
Date Submitted 04/06/2020
Status Grievance Review
Status Date 04/06/2020
Reason Eligibility error-DEN:Duplicate Application
Notes 04/06/2020:
Reason _
Notes 04/06/2020: Deny to test grievance process.
Reason _
Notes 04/06/2020: Deny to test grievance process.
Reason _
Notes 04/06/2020: Please reopen for processing.

8. Once the grievance is approved the Revalidation application is returned to an “Under Review” status. The application will be processed by an analyst and an email will be sent to the contact if there are any remaining issues.

Revision Log

| Revision Date | Section/Action | Pages | Made by |
|----------------------|--|---------------|---|
| 08/12/2020 | Provider Revalidation Manual Created | - | DXC |
| 10/01/2020 | Changed DXC references to fiscal agent | 50, 51, 54 | Gainwell Technologies (formerly DXC) |
| 10/2/2020 | Updated graphic | 8 | HCPF |
| 1/31/2022 | Updated graphic with fee | 8 | Gainwell Technologies |
| 3/30/2022 | Updated Provider Identification Panel | 14-17 | Gainwell Technologies |