



## Load Letter Request Form

**Note:** The Department will accept requests on this form only. Do not alter this form.

**Claims must be submitted within 365 days, even if the result is a denial.**

Providers are responsible for verifying member eligibility at time of service.

Refer to the [Billing Manuals web page](#) of the Department’s Web site to review timely processing requirements.

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### Provider Request

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Today’s Date: \_\_\_\_\_

**Member Information:**

Health First Colorado ID: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Dates of Service to be covered with the request: \_\_\_\_\_

Internal Control Number (ICN) that was previously submitted within 365 days from the date of service:

\_\_\_\_\_

**Return Response to:**

Medical Provider Name: \_\_\_\_\_ Provider Health First Colorado ID: \_\_\_\_\_

Name of Contact: \_\_\_\_\_ E-mail: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Check the box if **only a fax response** is wanted for this request.

Indicate the **reason for requesting a Load Letter:** \_\_\_\_\_

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Send this request form by **encrypted** email to: [hcpf\\_loadletterrequests@state.co.us](mailto:hcpf_loadletterrequests@state.co.us).

If unable to send encrypted email, fax to **303-866-2082**. No cover sheet is needed.

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