COLORADO
Department of Health Care Policy & Financing

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 General Provider Information Manual to review timely processing requirements.

Provider Request

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**: _____

_____

_____

Send this request form by **encrypted** email to: HCPF_LoadLetterRequests@state.co.us.

Revised: December 2024