



## Paying a Previously Waived Enrollment Application Fee

April 2022

Providers may follow the instruction below to pay an enrollment application fee previously waived during the public health emergency (PHE) if required for the provider type.

1. Log in to the [Provider Web Portal](#) and click "Provider Maintenance". Click "Provider Maintenance" again.

Note: The application fee is paid on the "Attachments and Submit" panel, which will be greyed out by default upon initial log in.

Provider Maintenance: Instructions <span style="float: right;">?</span>	
<b>Instructions</b> <a href="#">Change of Ownership</a> <a href="#">Specialty and Contact Information Changes</a> <a href="#">Address Changes</a> <a href="#">Provider Identification Changes</a> <a href="#">Language Changes</a> <a href="#">Other Information Changes</a> <a href="#">Network Participation Changes</a> <a href="#">Disclosure Changes</a> <a href="#">Attachments and Submit</a>	<p><b>Use these pages to submit any changes to your organizational information.</b>            Please select the link on the left to access the information you would like to update. After all the necessary changes are made you must submit the changes from the Attachments and Submit page.</p> <p><b>Important information:</b></p> <ul style="list-style-type: none"> <li>▪ After you have updated the necessary provider information, please visit the Manage Accounts page to review and update (if necessary) your delegate information.</li> </ul> <p style="text-align: right;"><a href="#">Continue</a> <a href="#">Cancel</a></p>



- 2. Complete any other maintenance updates that may be needed. If only paying the application fee, select any panel from the left navigation pane and then click "Go to Submit." In the example below, the "Language Changes" panel was selected.

**Provider Maintenance: Languages** ?

[Instructions](#)  
You are initiating a change request. Complete the desired changes for fields in each section and click the 'Continue' button to make additional changes. Or click the 'Go to Submit' button to submit your changes. Providers that have the ability to translate different languages for members should select the appropriate language(s) below. This field is not required. Click the **Remove** link to remove the row.

[Change of Ownership](#)

[Specialty and Contact Information Changes](#)

[Address Changes](#)

[Provider Identification Changes](#)

**Language Changes**

[Other Information Changes](#)

[Network Participation Changes](#)

[Disclosure Changes](#)

[Attachments and Submit](#)

Language	Action
<input type="checkbox"/> Click to collapse.	
Language <input type="text"/>	
<a href="#">Add</a>	

[Go to Submit](#) [Continue](#) [Cancel](#)

This action will activate the "Attachments and Submit" panel. Click "Attachments and Submit".



- Upload any attachments required for maintenance updates. If only paying the application fee, complete the "Application Fee" section, to include clicking the "Online Bill Pay" link to make the payment.

**Provider Maintenance: Attachments and Submit**

[Instructions](#) \* Indicates a required field.

[Change of Ownership](#)

[Specialty and Contact Information Changes](#)

[Address Changes](#)

[Provider Identification Changes](#)

[Language Changes](#)

[Other Information Changes](#)

[Network Participation Changes](#)

[Disclosure Changes](#)

**Attachments**

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](http://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.

To add an attachment, complete the required fields and click the **Add** button.

**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.				
	*Transmission Method	FT-File Transfer		
	*Upload File	<input type="text" value="Browse..."/>		
	*Attachment Type	<input type="text"/>		
<input type="button" value="Add"/> <input type="button" value="Cancel"/>				

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**Attachments and Submit**

**Application Fee**

The Affordable Care Act requires certain providers to remit an application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidation and change of ownership, as required, and is assessed in full for each service location enrolled in CO Medicaid.

Please answer all questions. If you answer "NO" to all of the following questions, you must pay an application fee. **If you answer "Yes" to any of the following questions, do not pay a fee, and click the Continue button instead.**

**Application Fee Questions**

**Medicare Enrollment - if the service location has enrolled or revalidated with Medicare within the last 5 years, is approved and paid an application fee, no fee is required.**

1. \*Are you an approved Medicare provider at this service location?  
 Yes  No

**Medicaid Enrollment - if the service location has enrolled or revalidated with another state's Medicaid or Children's Health Insurance Program within the last 5 years, is approved and paid an application fee, no fee is required. (Upload proof of payment in the Attachments section above.)**

2. \*Have you enrolled or revalidated in another State's Medicaid or Children's Health Insurance Program within the last 5 years?  
 Yes  No

**Financial Hardship - when requesting an application fee waiver, include a letter describing the financial hardship and why the hardship justifies an exception. Include any additional documentation in support of the request to help the Centers for Medicare and Medicaid Services (CMS) with the decision to waive or deny. Application processing will be delayed while CMS reviews and decides. (Upload the letter and documentation in the Attachments section above.)**

3. \*Are you requesting a waiver of the application fee because of financial hardship?  
 Yes  No

**Providers with Multiple Enrollments at the same Service Location Address - Providers shall only pay one application fee per service location address. (Upload proof of payment in the Attachments section above.)**

4. \*Has this service location address previously paid an application fee to Colorado Medicaid?  
 Yes  No

\*Amount Due 631.00

\* To make a payment, click the link below.  
[Online Bill Pay](#)

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**Submit**

Enter the required information below. Click Submit to send us your changes.

By checking this box, I declare, under penalty of perjury, that the information I have entered is true and correct.

\*I accept  Date 03/25/2022

\*Name of the Person Reporting Change



4. Under the "Submit" section, click the "I accept" checkbox, and enter the name of the person reporting the change. The "Submit" button will activate. Click "Submit". An auto-generated tracking number will be generated. Retain the tracking number for your records and to check the status of the request.

**Submit**

Enter the required information below. Click Submit to send us your changes.

By checking this box, I declare, under penalty of perjury, that the information I have entered is true and correct.

**\*I accept**  **Date** 03/25/2022

**\*Name of the Person Reporting Change**

**Submit** **Cancel**

