



Provider Application Fee Refund Request Form

Complete this form to submit a request for reimbursement of a provider application fee.

Provider Request

Provider Name: _____

Email: _____ Phone: _____

Provide a detailed explanation for your application fee refund request:

Note: Convenience Pay processing fees are non-refundable.

Tracking Number (ATN): _____ NPI #: _____

Payment Confirmation #: _____

Allow 30 days processing time to receive an approved refund. Refund will be credited back to the original credit/debit card or bank account used to make the payment.

Authorized Requestor Name: _____ Date: _____

Complete this form and mail to:

**Gainwell Technologies
P.O. Box 30
Denver, CO 80201**

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Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

www.colorado.gov/hcpf

