

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 prepopulated 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. Refer to the Provider Enrollment Manual located on the [Provider Enrollment web page](#) under Enrollment Resources 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

Ensure the latest version of one of the following browsers is installed to navigate through the revalidation application in the Provider Web Portal.

- Microsoft Edge
- Mozilla Firefox
- Safari
- Google Chrome

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

More Information on a Field


An asterisk (*) next to a field indicates it is required information.

Note: Panels with fields that display an asterisk may not be applicable for some provider type/specialty combinations. These fields can be left blank for those providers. However, if data is entered in one of the fields, then all the fields with an asterisk must be completed.

Additional information is available in certain fields by hovering the cursor over the ! symbol. Hovering over this symbol opens a box that gives more information about the field. The information box disappears when the cursor is moved.



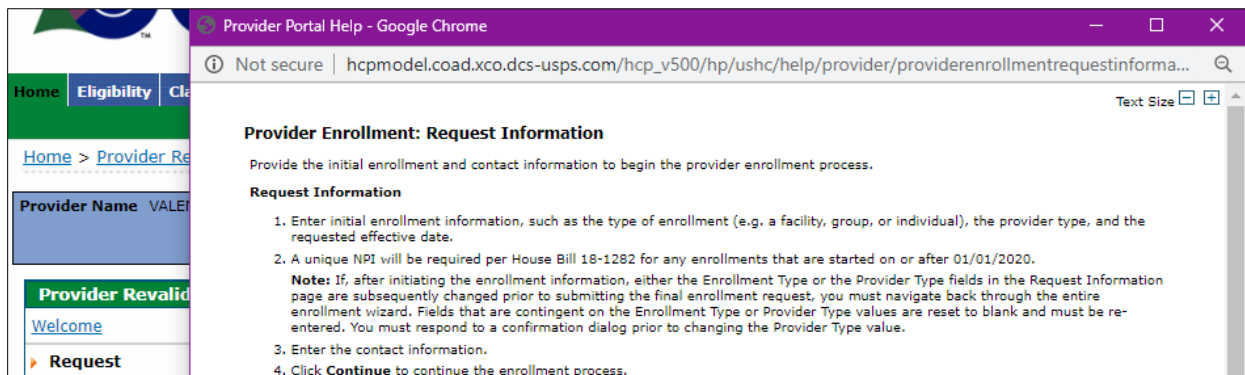
*Provider Type 

*Provider Type 

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

Help Feature on Each Page

A question mark symbol appears toward the top right corner of each panel. Clicking this symbol opens a dialog help window specific to the current screen:



Key Facts

Having the required information prior to beginning the revalidation process expedites the process. **Additional requirements vary depending on the provider type and enrollment type.**

Visit the [Provider Type Information for Revalidation 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 (RA) statements are sent if the provider is not receiving them electronically.

License Number (if applicable) – This is the identification number assigned by licensing agencies. Ensure that all alphanumeric characters, dots and dashes of the license number are entered, then attach a copy.

Certification Information (if applicable) – Additional certifications the provider wants included in the profile. Ensure that all alphanumeric characters of the certificate number are entered, then attach a copy.

Malpractice and Liability Insurance Information – Complete the insurance information.

Ownership/Controlling Interest and Conviction Disclosure Information

The following information is needed for each person or entity with an ownership or controlling interest of 5% or more, the Board of Directors, partners, managing employees, etc., in the enrolling provider:

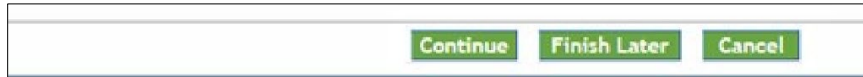
- Name
- Address
- Federal Employer ID Number (EIN) or Social Security Number (SSN) - for individuals
- Date of Birth (DOB) if an individual

Refer to the Disclosure Instructions located on the [Provider Forms web page](#) under the Provider Enrollment & Update Forms drop-down for more information.

- Disclosure Instructions EIN
- Disclosure Instructions SSN

Completing the Revalidation Application

The Provider Web Portal autosaves entered data during the revalidation process. There are three (3) buttons available at the bottom of each panel while completing the application.

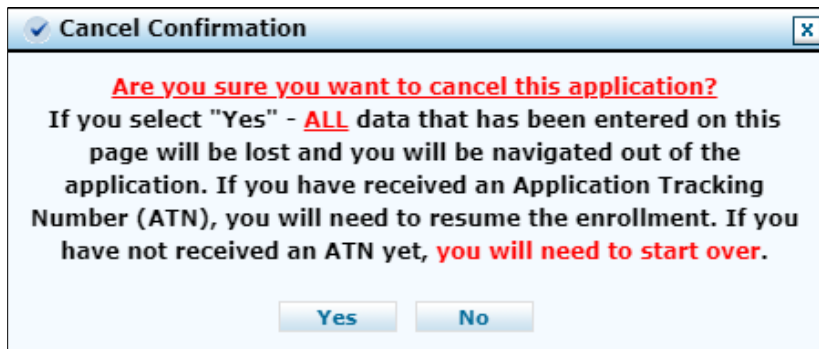


These buttons allow the user to:

Continue – Continues to the next panel of the revalidation application. The autosave process is initiated after reviewing data on the **Request Information** panel and clicking **Continue**. Each click of this button on subsequent panels automatically saves data entered on the current panel.

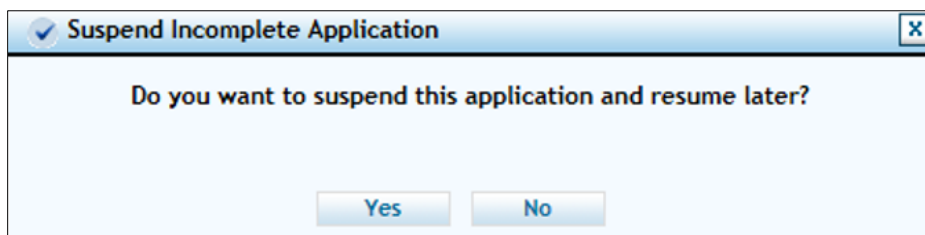
Cancel – Cancels the application process. If an Application Tracking Number (ATN) has been generated, this button prompts the end of the application process without saving the data on the **current** panel (data entered on **prior** panels is already saved). This button prompts the end of the application process **without saving the data** if an ATN has not been generated. A **Cancel Confirmation** notification appears before the user is allowed to proceed.

If **Yes** is clicked, all data entered on this panel and any previous panels will be lost if an ATN has not been generated.



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

Suspend Incomplete Application Pop Up



Clicking **No** returns the user to the revalidation process. Clicking **Yes** logs the user out of the revalidation application and assigns an Application Tracking Number (ATN) to the application. **It is important to retain the ATN for future use.**

Accessing the Provider Web Portal

1. Log in to [Provider Web Portal](#).

Home

Home

Monday 06/29/2020 09:31 AM MST

Login

*User ID

*Password

Log In

[Forgot User ID?](#)
Enter your User Name before clicking 'Forgot Password?'

[Forgot Password?](#)

[Register Now](#)

Provider enrollment

Provider services (forms, rates & billing manuals)

What's new? (bulletins, newsletters, updates)

[Website Requirements](#)

2. Click **Revalidation** as shown in the next screenshot.

Note: The date displaying next to **Revalidation Date** is the due date for the provider to complete revalidation.

User Details

Welcome

[My Profile](#)

[Manage Accounts](#)

Provider

Name John Doe

Provider ID 1234567

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](#)

Result: Providers are directed to the **Welcome** panel of revalidation.

Welcome Panel

| Provider Revalidation: Welcome | |
|--------------------------------|---|
| Welcome | Welcome to the Online Provider Revalidation Process |
| Request Information | Please complete each step in the revalidation process. Required fields are noted. You will be able to save the information and return using the tracking number assigned by the system. When you have completed all steps of the application, print a copy of the information for your records, "submit" and "confirm" the application for processing. |
| Specialties | |
| Addresses | Please click the "Continue" button to start the revalidation process. |
| Provider Identification | Want to make sure your application is processed as quickly as possible? |
| Languages | Please do NOT begin your application before reviewing all of the training resources available. Starting an application prior to reviewing the training materials will likely result in an incomplete or incorrect application. An incorrect or incomplete application requires additional review, which may add weeks of additional processing time. Please visit our Revalidation web page at: www.colorado.gov/pacific/hcpf/revalidation . Be sure to review the Information by Provider Type (link) before you begin the online trainings – it will help you select the correct training, right from the start. |
| Other Information | |
| Disclosures | |
| Attachments and Fees | |
| Agreement | |
| Summary | Continue Cancel |

Click the **Continue** button to start the revalidation process once the information is reviewed.

Request Information Panel

The **Request Information** panel displays after clicking **Continue** on the **Welcome** panel.

| Provider Revalidation: Request Information ? | |
|--|---|
| Welcome | <p>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".</p> <p>The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application.</p> <p>* Indicates a required field.</p> |
| Request Information | |
| Specialties | |
| Addresses | |
| Provider Identification | Initial Enrollment Information <p>This enrollment type is for an individual that renders service but does not bill Colorado Medicaid directly. The provider must be associated with a Group that submits claims on their behalf.</p> <ul style="list-style-type: none"> SSN only Must associate to a Group provider enrollment type <p>Enrollment Type Individual within Group Provider Type 05-Physician</p> |
| Network Participation | Provider Information <p>The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.</p> <p>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.</p> <p>NPI 1234567890 MCD 9000999999</p> <p>NPI Zip + 4 88888-8888 *Taxonomy 207L00000X-Anesthesiology</p> <hr/> <p>Tax ID Number 987654321 Tax ID Type SSN</p> |
| Languages | |
| Other Information | |
| Disclosures | |
| Attachments and Fees | Contact Information <p>*Last Name <input type="text" value="DOE"/></p> <p>*First Name <input type="text" value="JOHN"/></p> <p>Suffix <input type="text"/></p> <p>*Phone <input type="text" value="3035551212"/> Ext <input type="text"/></p> <p>Fax Number <input type="text"/></p> <p>*Contact Email <input type="text" value="johndoe@imaprovider.com"/></p> <p>*Confirm Email <input type="text" value="johndoe@imaprovider.com"/></p> <p>*Email For Provider Publications <input type="text" value="johndoe@imaprovider.com"/></p> <p>*Confirm Email <input type="text" value="johndoe@imaprovider.com"/></p> <p>Preferred Method of Communication <input type="text" value="Email"/></p> |
| Agreement | |
| Summary | <p>Continue Finish Later Cancel</p> |

The provider must verify that the contact information is current, and if necessary, update the information. This is the contact person who may be notified to answer questions regarding the revalidation application.

Fields that are view only:

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

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

The user will not be able to continue with the revalidation process if the Tax ID is an SSN and there is another actively enrolled provider in the system with the same SSN. Individuals (SSNs) are limited to one (1) enrollment.

The user will not be able to continue with the revalidation process if any of the taxonomies on file for the provider do not match at least one of the taxonomies listed in the NPPES NPI Registry.

Tracking Information

After clicking **Continue** on the **Request Information** panel, the **Tracking Information** panel displays the revalidation ATN. Click **Continue** to resume the revalidation application. The revalidation process automatically saves data entered on subsequent panels each time the user clicks **Continue**.

The screenshot shows a web interface titled "Provider Revalidation: Tracking Information" with a green header bar. In the top right corner of the header is a "Print Preview" button. Below the header, the main content area has a green background with white text. It states: "Your revalidation application has been assigned the following tracking number: 253013. Please retain the tracking number for your records." Below this, it says: "Your application has been saved. You must Resume your application and complete it and submit it." Then, under the heading "Application Processing Times:", it provides details about processing times (4-6 weeks average) and mentions that turnaround time may be longer for moderate or high risk providers, or those requiring additional documentation. It also states that users will be updated via email and that they cannot access or submit a maintenance request until revalidation is completed. At the bottom right of the panel is a green "Continue" button.

Provider Revalidation: Tracking Information Print Preview



Your revalidation application has been assigned the following tracking number: 253013.
Please retain the tracking number for your records.

Your application has been saved. You must Resume your application and complete it and submit it.

Application Processing Times:
Current application processing times average 4-6 weeks. This turnaround time will be shorter if your application was submitted completely and correctly. Likewise, your 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 application moves through the process. ***Please be aware you are not able to access your application after you submit it, unless your application requires correction. Also be aware that you will not be able to submit a Provider Maintenance request until this revalidation is completed.***

Continue

Specialties Panel

[Home](#) | [Eligibility](#) | [Claims](#) | [Care Management](#) | [Resources](#)

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

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

Provider Revalidation: Specialties

[Welcome](#)
[Request Information](#)
Specialties
[Addresses](#)
[Provider Identification](#)
[Languages](#)
[Other Information](#)
[Disclosures](#)
[Attachments and Fees](#)
[Agreement](#)
[Summary](#)

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

The **Specialties** and **Additional Taxonomies** sections may not be updated during revalidation. These sections may be updated with a separate maintenance request after the revalidation is complete.

Addresses Panel

Required fields and click the **Add** button. Click **Remove** to remove the entire row.

| Type | Address | City | State | Action |
|---|----------------------|------------------|----------|--------|
| <input checked="" type="checkbox"/> Mailing | 123 Mail | DENVER | Colorado | |
| <input checked="" type="checkbox"/> Billing | 123 Billing | DENVER | Colorado | |
| <input type="checkbox"/> Service Location | 123 Service Location | COLORADO SPRINGS | Colorado | |

***Address Type**

***Location Code**

***Address**

***City** **County**

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

Primary Email **Confirm Email**

Secondary Email **Confirm Email**

Phone **Ext**

Phone **Ext**

Phone **Ext**

Phone **Ext**

Service Address Information

If 'Address Type' is changed from 'Service', the service information below will be lost upon Add or Save of address.

Opt Out of Provider Directory ☐

Accepting New Members ☐ **ADA Compliant** ☐ **Accepting New Members with Special Needs** ☐

TDD Capability ☐ **Phone** **Ext**

TTY Capability ☐ **Phone** **Ext**

Save **Reset** **Cancel**

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

Continue **Finish Later** **Cancel**

The provider may update the following on this panel:

- Service Location
- Billing Address
- Mailing Address

Select the **Address Type** drop-down to update this information. Click **Save** to save the updated information; click **Reset** to refresh the information; or click **Cancel** to cancel the update within this section.

Provider Identification Panel

Note: Providers must select at least one (1) payer. Providers are required to view and electronically sign a Provider Participation Agreement (PPA) specific to each payer selected.

| Provider Revalidation: Provider Identification | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|--------------------|--------|--------------------|--------|--------------------|--|--|--|---------|--|--|--|---------|--|--|--|---------------------|--|--|--|---|--|--|--|
| Welcome | * Indicates a required field. | | | | | | | | | | | | | | | | | | | | | | | | |
| Request Information | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specialties | | | | | | | | | | | | | | | | | | | | | | | | | |
| Addresses | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider Identification | Provider Legal Name The provider legal name and information is provided once for each enrollment. Last Name DOE First Name JOHN Middle _ Suffix _ Doing Business As Counseling Services | | | | | | | | | | | | | | | | | | | | | | | | |
| Network Participation | | | | | | | | | | | | | | | | | | | | | | | | | |
| Languages | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Information | | | | | | | | | | | | | | | | | | | | | | | | | |
| Disclosures | | | | | | | | | | | | | | | | | | | | | | | | | |
| Attachments and Fees | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agreement | | | | | | | | | | | | | | | | | | | | | | | | | |
| Summary | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Individual Providers Gender Male Birth Date 01/01/2000 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. <table border="1"> <thead> <tr> <th>Degree</th> <th>School</th> <th>Year of Graduation</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="4">Click to collapse.</td> </tr> <tr> <td>*Degree</td> <td></td> <td></td> <td></td> </tr> <tr> <td>*School</td> <td></td> <td></td> <td></td> </tr> <tr> <td>*Year of Graduation</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="4"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </td> </tr> </tbody> </table> | Degree | School | Year of Graduation | Action | Click to collapse. | | | | *Degree | | | | *School | | | | *Year of Graduation | | | | <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | |
| Degree | School | Year of Graduation | Action | | | | | | | | | | | | | | | | | | | | | | |
| Click to collapse. | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Degree | | | | | | | | | | | | | | | | | | | | | | | | | |
| *School | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Year of Graduation | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Organizational Structure Select the applicable type of business. Organization Type Corporation | | | | | | | | | | | | | | | | | | | | | | | | |
| | Payer Select at least one payer. Providers will be required to view and electronically sign a Provider Participation Agreement (PPA) specific to each payer selected. *Payer <input type="checkbox"/> Colorado BHA <input checked="" type="checkbox"/> Title XIX Payer | | | | | | | | | | | | | | | | | | | | | | | | |

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 here to search for a Colorado Department of Regulatory Agencies (DORA) license. 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"/> | DEN.0000123 | 01/01/2018 | 02/28/2022 | Active | |
| <input type="checkbox"/> Click to add new license or renew existing license | | | | | |

Expanded view of a license record

| License | | | | | |
|---|-------------|----------------|-----------------|--------|--------|
| <p>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 here to search for a Colorado Department of Regulatory Agencies (DORA) license.</p> <p>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.</p> | | | | | |
| | License # | Effective Date | Expiration Date | Status | Action |
| <input type="checkbox"/> | DEN.0000123 | 01/01/2018 | 02/28/2022 | Active | |
| <p>Enter the entire license ID including alpha, numeric, dots, dashes, etc. If the Issuing Authority is the Colorado Department of Regulatory Agencies (DORA), an automatic license look up will be performed. If a matching license record is found, the data will be returned for review. If no matching license record is found, manually enter the license information.</p> <p>*Issuing Authority <input type="text" value="Colorado DORA"/> License # <input type="text" value="DEN.0000123"/></p> <p>Effective Date <input type="text" value="01/01/2018"/> *Expiration Date <input type="text" value="02/28/2022"/></p> <p>*Issuing State <input type="text" value="Colorado"/> Description <input type="text" value="Test Description A"/></p> <p>*Type <input type="text" value="Primary"/> Status <input type="text" value="Active"/></p> <p><input type="button" value="Save"/> <input type="button" value="Reset"/> <input type="button" value="Cancel"/></p> | | | | | |
| <p><input type="checkbox"/> Click to add new license or renew existing license</p> | | | | | |

Adding a new license with a different number

| License | | | | | |
|--|-------------|----------------|-----------------|--------|--------|
| <p>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 here to search for a Colorado Department of Regulatory Agencies (DORA) license.</p> <p>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.</p> | | | | | |
| | License # | Effective Date | Expiration Date | Status | Action |
| <input type="checkbox"/> | DEN.0000123 | 01/01/2018 | 02/28/2022 | Active | |
| <p><input type="checkbox"/> Click to collapse.</p> | | | | | |
| <p>Enter the entire license ID including alpha, numeric, dots, dashes, etc. If the Issuing Authority is the Colorado Department of Regulatory Agencies (DORA), an automatic license look up will be performed. If a matching license record is found, the data will be returned for review. If no matching license record is found, manually enter the license information.</p> <p>If renewing an existing license, select the license record <input type="text"/></p> <p>If adding a new license, enter data in the following fields:</p> <p>*Issuing Authority <input type="text"/> *License # <input type="text"/></p> <p>*Effective Date <input type="text"/> *Expiration Date <input type="text"/></p> <p>*Issuing State <input type="text"/> Description <input type="text"/></p> <p>*Type <input type="text"/></p> <p><input type="button" value="Add"/> <input type="button" value="Reset"/></p> | | | | | |

Renewing an existing license with the same number

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 [here](#) to search for a Colorado Department of Regulatory Agencies (DORA) license.

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 |
|--|-------------|----------------|-----------------|--------|--------|
| | DEN.0000123 | 01/01/2018 | 02/28/2022 | Active | |

Click to collapse.

Enter the entire license ID including alpha, numeric, dots, dashes, etc. If the Issuing Authority is the Colorado Department of Regulatory Agencies (DORA), an automatic license look up will be performed. If a matching license record is found, the data will be returned for review. If no matching license record is found, manually enter the license information.

If renewing an existing license, select the license record

If adding a new license, enter data in the following fields:

*Issuing Authority License #

*Effective Date *Expiration Date

*Issuing State Description

*Type

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 Number | Certification Type | Effective Date | End Date | Action |
|--|-----------------------|--------------------|--------------------------|----------------|------------|------------------------|
| | Clinic - Practitioner | AA123 | National Specialty Board | 01/01/2023 | 12/31/2023 | Remove |

Click to add certification.

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 |
|--|--------------------|----------------|----------|--------|
| | Click to collapse. | | | |

*DEA # *Effective Date *End Date

Within this panel, the provider may:

- Update the Doing Business As name. This field is optional.
- Add new license information or renew an existing license (if applicable). Ensure all alphanumeric characters, dots and dashes are entered.
 - If the license is a Colorado Department of Regulatory Agencies (DORA), an automatic lookup is performed when the **Issuing Authority** and **License #** are entered. If a match is found in DORA, the **Effective Date**, **Expiration Date**, and **Issuing State** are retrieved and populated automatically.
- Review and update the **Expiration Date** for an existing license.
Note: The expiration date can be changed to an earlier date for an existing license; however, it cannot be extended. Extending the expiration date is considered a renewal.
- Review the **Certification** section for updates. Existing certification records may have a **Certification Type** that is no longer valid. Review each certification record and select a new **Certification Type**, if applicable.
- Review and update the U.S. Drug Enforcement Administration (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**
- **Organization Type**
- Existing license information (excluding the **Expiration Date** field)
- Expired license information
- Existing DEA license information (excluding the **End Date** field)

| Provider Revalidation: Provider Identification | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------------------|--------|--------------------|--------|---|--|--|--|---------|--|--|--|---------|--|--|--|---------------------|--|--|--|---|--|--|--|
| Welcome Request Information Specialties Addresses Provider Identification Network Participation Languages Other Information Disclosures Attachments and Fees Agreement Summary | <p>* Indicates a required field.</p> <p>Provider Legal Name</p> <p>The provider legal name and information is provided once for each enrollment.</p> <div> <div>Last Name DOE</div> <div>First Name JOHN</div> <div>Middle _</div> <div>Suffix _</div> </div> <p>Doing Business As John Doe Provider</p> <p>Individual Providers</p> <p>Gender Male Birth Date 01/01/2000</p> <p>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.</p> <table border="1"> <thead> <tr> <th>Degree</th> <th>School</th> <th>Year of Graduation</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="4"> <input type="checkbox"/> Click to collapse. </td> </tr> <tr> <td>*Degree</td> <td></td> <td></td> <td></td> </tr> <tr> <td>*School</td> <td></td> <td></td> <td></td> </tr> <tr> <td>*Year of Graduation</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="4"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </td> </tr> </tbody> </table> <p>Organizational Structure</p> <p>Select the applicable type of business.</p> <p>Organization Type Corporation</p> | Degree | School | Year of Graduation | Action | <input type="checkbox"/> Click to collapse. | | | | *Degree | | | | *School | | | | *Year of Graduation | | | | <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | |
| Degree | School | Year of Graduation | Action | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Click to collapse. | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Degree | | | | | | | | | | | | | | | | | | | | | | | | | |
| *School | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Year of Graduation | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | | | | | | | | | | | | | | | | | | | | | | |

Network Participation Panel

| Provider Revalidation: Network Participation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|----------------|------------|------------------------|--|----------------------|----------------|----------|--------|--------------------------|------------------------|------------|------------|------------------------|--------------------------|--------------------------|------------|------------|------------------------|--------------------------|--------------------------------|------------|------------|------------------------|--------------------------|-----------------------------------|--|--|--|
| Welcome | Managed Care Network Participation | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Request Information | * Indicates a required field. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Specialties | 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Addresses | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider Identification | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Network Participation | <table border="1"> <thead> <tr> <th></th> <th>Managed Care Network</th> <th>Effective Date</th> <th>End Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>CHP+ - Colorado Access</td> <td>06/01/2001</td> <td>12/31/2299</td> <td>Remove</td> </tr> <tr> <td><input type="checkbox"/></td> <td>CHP+ - Kaiser Permanente</td> <td>06/01/2001</td> <td>12/31/2299</td> <td>Remove</td> </tr> <tr> <td><input type="checkbox"/></td> <td>CHP+ - Rocky Mountain HMO Inc.</td> <td>06/01/2001</td> <td>12/31/2299</td> <td>Remove</td> </tr> <tr> <td><input type="checkbox"/></td> <td colspan="4">Click to add Managed Care Network</td> </tr> </tbody> </table> | | | | | Managed Care Network | Effective Date | End Date | Action | <input type="checkbox"/> | CHP+ - Colorado Access | 06/01/2001 | 12/31/2299 | Remove | <input type="checkbox"/> | CHP+ - Kaiser Permanente | 06/01/2001 | 12/31/2299 | Remove | <input type="checkbox"/> | CHP+ - Rocky Mountain HMO Inc. | 06/01/2001 | 12/31/2299 | Remove | <input type="checkbox"/> | Click to add Managed Care Network | | | |
| | Managed Care Network | Effective Date | End Date | Action | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | CHP+ - Colorado Access | 06/01/2001 | 12/31/2299 | Remove | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | CHP+ - Kaiser Permanente | 06/01/2001 | 12/31/2299 | Remove | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | CHP+ - Rocky Mountain HMO Inc. | 06/01/2001 | 12/31/2299 | Remove | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Click to add Managed Care Network | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Languages | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Disclosures | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Attachments and Fees | Continue Finish Later Cancel | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Agreement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Summary | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

The **Network Participation** panel is where providers may review and update any managed care networks in which they participate. Adding a network option does not create an enrollment into that network. Additionally, a copy of the signed contract or a completed Network Participation Verification Form, located on the [Provider Forms web page](#) under the Provider Enrollment & Update Forms drop-down, must be scanned and attached on the **Attachments and Fees** panel.

Provider Revalidation: Network Participation

Managed Care Network

* Indicates a required field. Fields marked required. Click "+" to view or up required fields and click.

ASOD - DentaQuest USA Insurance CO
 CHP+ - Colorado Access
 CHP+ - DentaQuest USA
 CHP+ - Denver Health Medical Plan Inc.
 CHP+ - Kaiser Permanente
 CHP+ - Rocky Mountain HMO Inc.
 MCO - Denver Health Medical Choice
 MCO - Rocky Mountain Health Plans Prime
 PACE - InnovAge /Total Longterm Care Denver
 PACE - InnovAge /Total Longterm Care Lakewood
 PACE - InnovAge /Total Longterm Care Loveland
 PACE - InnovAge /Total Longterm Care Pueblo
 PACE - InnovAge /Total Longterm Care Thornton
 PACE - InnovAge/Total Longterm Care Aurora
 PACE - Rocky Mountain Health Care Services
 PACE - TRU Community Care
 RAE - (Region 1) Rocky Mountain Health Plans
 RAE - (Region 2) Northeast Health Partners
 RAE - (Region 3) Colorado Access

***Network**

End Date

Add

Continue **Finish Later** **Cancel**

This section is *not required* – even though there is an asterisk (*).

Click the **Add** button once a network and its effective date are selected to add it to the list. The **End Date** is optional.

Network Participation Panel – MCO/RAE Add Network

Managed Care Network **Effective Date** **End Date** **Action**

☐ Click to collapse.




***Network** MCO - Rocky Mountain I ***Effective Date** 01/01/2022

End Date

Add

Click the + sign next to **Click to add Managed Care Network** to add another network if a provider is a member of more than one (1) network. Repeat the steps above until this panel is complete.

Network Participation Panel – MCO/BHO Network Add another MCO Network

| | Managed Care Network | Effective Date | End Date | Action |
|--|---|----------------|------------|------------------------|
|  | MCO - Rocky Mountain Health Plans Prime | 01/01/2022 | 12/31/2299 | Remove |
|  | Click to add Managed Care Network | | | |
| <div></div> | | | | |
| <div>Continue Finish Later Cancel</div> | | | | |

Click **Continue**, **Finish Later** or **Cancel** when the panel is complete.

Languages Panel

Provider Revalidation: Languages

Welcome

Request Information

Specialties

Addresses

Provider Identification

Languages

Other Information

Disclosures

Attachments and Fees

Agreement

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 | Proficiency | Action |
|--------------------|-------------|--------|
| Click to collapse. | | |
| *Language | Proficiency | |
| Add | | |

Continue Finish Later Cancel

The provider may review and update up to 60 languages and the proficiency level spoken within the office or facility. Click the **Add** button after each language and proficiency level is selected. The screen updates and adds 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 | Proficiency | Action |
|--------------------|---------------------------|--------|
| Click to collapse. | | |
| *Language | Proficiency | |
| English | Native/Bilingual Proficie | |
| Add | | |

Continue Finish Later Cancel

Click the **Remove** link in the **Action** column to remove a language.

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 | Proficiency | Action |
|------------------------|------------------------------|--------|
| English | Native/Bilingual Proficiency | Remove |
| Click to add language. | | |

Continue Finish Later Cancel

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 | Malpractice/General Liability Insurance | | | | | | | | | | | | | | |
| Addresses | 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. | | | | | | | | | | | | | | |
| Provider Identification | All Applicants must complete, Malpractice/General liability insurance is mandatory under current State and Federal law. | | | | | | | | | | | | | | |
| Languages | <table border="1"> <thead> <tr> <th>Name</th> <th>Policy ID</th> <th>Effective Date</th> <th>Expiration Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Insurance Carrier</td> <td>123456</td> <td>01/01/2019</td> <td>12/31/2019</td> <td></td> </tr> </tbody> </table> | | | | | Name | Policy ID | Effective Date | Expiration Date | Action | <input type="checkbox"/> Insurance Carrier | 123456 | 01/01/2019 | 12/31/2019 | |
| Name | Policy ID | Effective Date | Expiration Date | Action | | | | | | | | | | | |
| <input type="checkbox"/> Insurance Carrier | 123456 | 01/01/2019 | 12/31/2019 | | | | | | | | | | | | |
| Other Information | <input type="checkbox"/> Click to collapse. | | | | | | | | | | | | | | |
| Disclosures | <div> <div>*Carrier Name Insurance Carrier</div> <div>*Policy ID 123456</div> <div>*Insurance Type PRIVATE INSURANCE</div> <div>*Effective Date 01/01/2020</div> <div>*Expiration Date 12/31/2020</div> </div> | | | | | | | | | | | | | | |
| Fingerprinting | <div> <div>Add</div> <div>Reset</div> </div> | | | | | | | | | | | | | | |
| Attachments and Fees | | | | | | | | | | | | | | | |
| Agreement | | | | | | | | | | | | | | | |
| Summary | | | | | | | | | | | | | | | |

| Supplemental Questions | |
|--|--|
| PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE | |
| Medicaid Participation | |
| 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)? <input type="radio"/> Yes <input type="radio"/> 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)? <input type="radio"/> Yes <input type="radio"/> 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)? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No *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? <input type="radio"/> Yes <input type="radio"/> No *Have you ever been excluded from participation in federal procurement? <input type="radio"/> Yes <input type="radio"/> No *Do you hold all licenses and certifications as required based on your provider type? <input type="radio"/> Yes <input type="radio"/> No *Is this license expired, or subject to conditions or restrictions? <input type="radio"/> Yes <input type="radio"/> No *Have you ever been subject to a payment suspension based on a credible allegation of fraud? <input type="radio"/> Yes <input type="radio"/> No *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? <input type="radio"/> Yes <input type="radio"/> No | |

Substance Use Disorder (SUD) Disorder Facilities

The following section displays for a facility enrollment with Provider Type 64 SUD Continuum.

Substance Use Disorder Bed Information

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.

Total Number of Active SUD Beds: 28

Substance Use Disorder applicants must complete. The Bed Type, Number of SUD allocated beds in the facility, Effective Date, and End Date are all required.

Note: The number of beds must be counted by the number of beds - based on staffing and facility design intended to serve withdrawal management (WM) level of care and the number of beds intended to serve non-WM SUD treatment level of care. The total number of beds allocated for SUD services in the facility should be the sum of these two counts. Do not count the same bed in both categories.

Outpatient programs should enter zero "0" in the "Number of SUD Beds" field.

When entering the Effective Date:

- enter today's date or;
- if submitting a change in the number of beds, enter the date when the change in bed count was effective.

When entering the End Date, a future date may be entered (e.g. 12/31/2299) to avoid the need to update the system if no changes to bed counts occur.

| | Bed Type | Number of SUD Beds | Effective Date | End Date | Action |
|----------------------|------------|--------------------|----------------|------------|--------|
| + | Historical | 28 | 01/01/2021 | 12/31/2299 | |
| - Click to collapse. | | | | | |

***Bed Type**

***Effective Date**

***Number of SUD Beds**

***End Date**

Bed Type – Select a bed type for this required field. The values displayed in the drop-down list will be determined by the provider's active specialties. Possible values are **Facility Residential** and **Facility Residential Withdrawal**.

Number of SUD Beds – Enter up to five (5) numeric characters in this required field for the number of beds in an SUD facility that are certified and/or licensed.

Effective Date – Enter eight (8) characters in this required field using the **MM/DD/YYYY** format for the effective date of the SUD bed.

End Date – Enter eight (8) characters in this required field using the **MM/DD/YYYY** format for the end date of the SUD bed.

At least one active SUD bed record must be present before proceeding with the revalidation. If an SUD bed record with a **Bed Type** of **Historical** is displayed upon beginning the revalidation application, an active record for bed types of **Facility Residential** and **Facility Residential Withdrawal** must be entered. The **Historical** record displays SUD bed information prior to the bed types being separated in the application.

Substance Use Disorder Bed Information

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.

Total Number of Active SUD Beds: 17

Substance Use Disorder applicants must complete. The Bed Type, Number of SUD allocated beds in the facility, Effective Date, and End Date are all required.

Note: The number of beds must be counted by the number of beds - based on staffing and facility design intended to serve withdrawal management (WM) level of care and the number of beds intended to serve non-WM SUD treatment level of care. The total number of beds allocated for SUD services in the facility should be the sum of these two counts. Do not count the same bed in both categories.

Outpatient programs should enter zero "0" in the "Number of SUD Beds" field.

When entering the Effective Date:

- enter today's date or;
- if submitting a change in the number of beds, enter the date when the change in bed count was effective.

When entering the End Date, a future date may be entered (e.g. 12/31/2299) to avoid the need to update the system if no changes to bed counts occur.

| | Bed Type | Number of SUD Beds | Effective Date | End Date | Action |
|---|---|--------------------|----------------|------------|------------------------|
| + | Historical | 28 | 01/01/2021 | 12/31/2023 | |
| + | Facility Residential | 5 | 01/01/2024 | 12/31/2299 | Remove |
| + | Facility Residential Withdrawal | 12 | 01/01/2024 | 12/31/2299 | Remove |
| + | Click to add Substance Use Disorder Beds. | | | | |

Note: Select SUD Continuum specialties do not allow SUD bed records to be entered. For those specialties, the SUD bed records will have the Number of SUD Beds set to zero (0) for both bed types and cannot be changed.

Substance Use Disorder Bed Information

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.

Total Number of Active SUD Beds: 0

Substance Use Disorder applicants must complete. The Bed Type, Number of SUD allocated beds in the facility, Effective Date, and End Date are all required.



Note: The number of beds must be counted by the number of beds - based on staffing and facility design intended to serve withdrawal management (WM) level of care and the number of beds intended to serve non-WM SUD treatment level of care. The total number of beds allocated for SUD services in the facility should be the sum of these two counts. Do not count the same bed in both categories.

Outpatient programs should enter zero "0" in the "Number of SUD Beds" field.

When entering the Effective Date:

- enter today's date or;
- if submitting a change in the number of beds, enter the date when the change in bed count was effective.

When entering the End Date, a future date may be entered (e.g. 12/31/2299) to avoid the need to update the system if no changes to bed counts occur.

| | Bed Type | Number of SUD Beds | Effective Date | End Date | Action |
|---|---------------------------------|--------------------|----------------|------------|--------|
|  | Facility Residential | 0 | 11/24/2023 | 12/31/2299 | |
|  | Facility Residential Withdrawal | 0 | 11/24/2023 | 12/31/2299 | |

The following section displays for an individual enrollment with Provider Type 24 Non-Physician Practitioner Individual (Registered Nurses only):

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. | | | | |
| Last Name <input style="width: 150px;" type="text"/> NPI <input style="width: 80px;" type="text"/> | First Name <input style="width: 150px;" type="text"/> | | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | |

Within this panel, the provider may:

- Review and update information in the **Malpractice/General Liability Insurance** section.
- Answer the **Supplemental Questions**. Each question must be answered before the provider can continue.
- Review and update **Institutional Bed** information. The license showing the number of hospital beds must be attached if updating bed information.
- Review and update the website address.

Registered Nurses are required to complete and attach the RN Supervision Form, located on the [Provider Forms web page](#) under the Provider Enrollment & Update Forms drop-down.

Note: Insurance information is required for all provider types. Only some provider types are required to include an insurance attachment. Visit the [Provider Type Information for Revalidation web page](#) to determine if your provider type is required to attach proof of insurance policy.

Additional Provider Search Options Section

This optional section presents the appropriate subsections based on the enrolled provider. All providers will see the optional subsections of **Community Association**, **Cultural Competency**, and **Preferred Name**. Select providers will see additional subsections of **Alternate Provider Addresses** and **Servicing Counties**.

| Additional Provider Search Options | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|------------------------------------|----------------------------|--------------------------|--------|-----------------------|-----------|--------------------|--------------------|---|--------|--|---------------------------------|--|---------------------|--|--|--|------------------------------------|--|--|--|--|--|-------------------------------------|--|--|--|--|--|-------------------------------|--|--|--|--|--|----------------------------|-----------------------------|--|--|--|--|-----------------------------|--------------------------------|--|--|--|--|------------------------------------|------------------------------------|--|--|--|--|--------------------------------------|------------------------------------|--|--|--|--|----------------------------|--------------------------|----------------------------|--------------------------|--|--|----------------------------|--------------------------|----------------------------|--------------------------|--|--|---|--|--|--|--|--|
| Data entered in the optional fields below will be searchable in the Health First Colorado Find a Doctor website. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Association | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Select any Community Associations that the provider belongs to. 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"><thead><tr><th>Community Association</th><th>Action</th></tr></thead><tbody><tr><td colspan="2">Click to collapse.</td></tr><tr><td>*Community Association <input type="text"/></td><td></td></tr><tr><td colspan="2">Add</td></tr></tbody></table> | | | | | Community Association | Action | Click to collapse. | | *Community Association <input type="text"/> | | Add | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Association | Action | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Click to collapse. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Community Association <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Add | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cultural Competency | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Select any Cultural Competencies that the provider offers. 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"><thead><tr><th>Cultural Competency</th><th>Action</th></tr></thead><tbody><tr><td colspan="2">Click to collapse.</td></tr><tr><td>*Cultural Competency <input type="text"/></td><td></td></tr><tr><td colspan="2">Add</td></tr></tbody></table> | | | | | Cultural Competency | Action | Click to collapse. | | *Cultural Competency <input type="text"/> | | Add | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cultural Competency | Action | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Click to collapse. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Cultural Competency <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Add | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alternate Provider Addresses | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Enter alternate provider address information that is not the Service Location, Mailing, or Billing address. This section is not required. 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"><thead><tr><th>Type</th><th>Address</th><th>City</th><th>State</th><th colspan="2">Action</th></tr></thead><tbody><tr><td colspan="6">Click to collapse.</td></tr><tr><td>*Address Type <input type="text"/></td><td colspan="5"></td></tr><tr><td>*Location Code <input type="text"/></td><td colspan="5"></td></tr><tr><td>*Address <input type="text"/></td><td colspan="5"></td></tr><tr><td>*City <input type="text"/></td><td colspan="2">County <input type="text"/></td><td colspan="3"></td></tr><tr><td>*State <input type="text"/></td><td colspan="2">*Zip Code <input type="text"/></td><td colspan="3"></td></tr><tr><td>Primary Email <input type="text"/></td><td colspan="2">Confirm Email <input type="text"/></td><td colspan="3"></td></tr><tr><td>Secondary Email <input type="text"/></td><td colspan="2">Confirm Email <input type="text"/></td><td colspan="3"></td></tr><tr><td>Phone <input type="text"/></td><td>Ext <input type="text"/></td><td>Phone <input type="text"/></td><td>Ext <input type="text"/></td><td colspan="2"></td></tr><tr><td>Phone <input type="text"/></td><td>Ext <input type="text"/></td><td>Phone <input type="text"/></td><td>Ext <input type="text"/></td><td colspan="2"></td></tr><tr><td colspan="6">Add Reset</td></tr></tbody></table> | | | | | | Type | Address | City | State | Action | | Click to collapse. | | | | | | *Address Type <input type="text"/> | | | | | | *Location Code <input type="text"/> | | | | | | *Address <input type="text"/> | | | | | | *City <input type="text"/> | County <input type="text"/> | | | | | *State <input type="text"/> | *Zip Code <input type="text"/> | | | | | Primary Email <input type="text"/> | Confirm Email <input type="text"/> | | | | | Secondary Email <input type="text"/> | Confirm Email <input type="text"/> | | | | | Phone <input type="text"/> | Ext <input type="text"/> | Phone <input type="text"/> | Ext <input type="text"/> | | | Phone <input type="text"/> | Ext <input type="text"/> | Phone <input type="text"/> | Ext <input type="text"/> | | | Add Reset | | | | | |
| Type | Address | City | State | Action | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Click to collapse. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Address Type <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Location Code <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Address <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *City <input type="text"/> | County <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *State <input type="text"/> | *Zip Code <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary Email <input type="text"/> | Confirm Email <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Secondary Email <input type="text"/> | Confirm Email <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone <input type="text"/> | Ext <input type="text"/> | Phone <input type="text"/> | Ext <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone <input type="text"/> | Ext <input type="text"/> | Phone <input type="text"/> | Ext <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Add Reset | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Servicing Counties | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Select the counties served for any of the provider's enrolled specialties. 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"><thead><tr><th>Servicing County</th><th>Specialty</th><th>Action</th></tr></thead><tbody><tr><td colspan="3">Click to collapse.</td></tr><tr><td>*Servicing County <input type="text"/></td><td>*Specialty <input type="text"/></td><td></td></tr><tr><td colspan="3">Add</td></tr></tbody></table> | | | | | Servicing County | Specialty | Action | Click to collapse. | | | *Servicing County <input type="text"/> | *Specialty <input type="text"/> | | Add | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Servicing County | Specialty | Action | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Click to collapse. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Servicing County <input type="text"/> | *Specialty <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Add | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Preferred Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Enter a Preferred Name that is different than the legal or doing business as name. The Preferred Name should be the name the community knows the entity as. This field is not required. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Preferred Name <input type="text"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Community Association

All providers may identify specific community associations and add as many as needed. This information is searchable on the [Health First Colorado Find a Doctor web page](#).

Click the **Add** button after each **Community Association** is selected. The screen updates and adds the selected item. Add as many **Community Association** records as needed. Click the **Remove** link to remove a record.

| Community Association | |
|--|------------------------|
| Select any Community Associations that the provider belongs to. 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. | |
| Community Association | Action |
| Association of Native American Medical Students | Remove |
| <input type="checkbox"/> Click to collapse. | |
| *Community Association | <input type="text"/> |
| <input type="button" value="Add"/> | |

Cultural Competency

All providers may identify specific cultural competencies and add as many as needed. This information is searchable on the [Health First Colorado Find a Doctor web page](#).

Click the **Add** button after each **Community Association** is selected. The screen updates and adds the selected item. Add as many **Community Association** records as needed. Click the **Remove** link to remove a record.

| Cultural Competency | |
|---|------------------------|
| Select any Cultural Competencies that the provider offers. 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. | |
| Cultural Competency | Action |
| ASL translator on staff | Remove |
| <input type="checkbox"/> Click to collapse. | |
| *Cultural Competency | <input type="text"/> |
| <input type="button" value="Add"/> | |

Preferred Name

All providers may specify a preferred name different than the legal name or Doing Business As (DBA) name. The **Preferred Name** should be the name for which the community knows the entity. This information is searchable on the [Health First Colorado Find a Doctor web page](#).

| Preferred Name | |
|---|----------------------|
| Enter a Preferred Name that is different than the legal or doing business as name. The Preferred Name should be the name the community knows the entity as. This field is not required. | |
| Preferred Name | <input type="text"/> |

Alternate Provider Addresses

Select providers may enter up to three (3) alternate addresses different than the service location, mailing and billing addresses entered on the **Addresses** panel. This information is searchable on the [Health First Colorado Find a Doctor web page](#).

Click the **Add** button after each address record is populated. The screen updates and adds the address. Up to three (3) addresses can be added. Click the **Remove** link to remove a record.

Complete address information, a primary email, and an office phone must be entered to add an address.

| Alternate Provider Addresses | | | | | | | | | |
|---|--------------------|------------|-----|---------------|--------------------|--------|--|-----|--|
| Enter alternate provider address information that is not the Service Location, Mailing, or Billing address. This section is not required. 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. | | | | | | | | | |
| Type | Address | | | City | State | Action | | | |
| <input type="checkbox"/> Click to collapse. | | | | | | | | | |
| *Address Type | Alternate 1 | | | | | | | | |
| *Location Code | In-State | | | | | | | | |
| *Address | 123 Main Street | | | | | | | | |
| | Suite 100 | | | | | | | | |
| *City | Denver | | | County | | | | | |
| *State | Colorado | | | *Zip Code | 888888888 | | | | |
| Primary Email | provider@email.com | | | Confirm Email | provider@email.com | | | | |
| Secondary Email | | | | Confirm Email | | | | | |
| Phone | Office | 1234567890 | Ext | | Phone | | | Ext | |
| Phone | | | Ext | | Phone | | | Ext | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | | | | | | |

| Alternate Provider Addresses | | | | | |
|--|-------------|-----------------|--------|----------|---|
| <p>Enter alternate provider address information that is not the Service Location, Mailing, or Billing address. This section is not required. Fields marked required in this section are only required if any information is entered in this section.</p> <p>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.</p> | | | | | |
| | Type | Address | City | State | Action |
| <input type="checkbox"/> | Alternate 1 | 123 Main Street | Denver | Colorado | Copy Remove |
| <input type="checkbox"/> Click to collapse. | | | | | |
| <div> <div>*Address Type <input type="text"/></div> <div>*Location Code <input type="text"/></div> <div>*Address <input type="text"/></div> <div>*City <input type="text"/></div> <div>*State <input type="text" value="Colorado"/></div> <div>Primary Email <input type="text"/></div> <div>Secondary Email <input type="text"/></div> <div>Phone <input type="text"/></div> <div>Phone <input type="text"/></div> </div> <div> <div>County <input type="text"/></div> <div>*Zip Code <input type="text"/></div> <div>Confirm Email <input type="text"/></div> <div>Confirm Email <input type="text"/></div> <div>Phone <input type="text"/></div> <div>Phone <input type="text"/></div> </div> | | | | | |
| <input type="button" value="Add"/> <input type="button" value="Reset"/> | | | | | |

Servicing Counties

Select providers may identify the specific counties served for any of the actively enrolled specialties. **All Specialties** may be selected in the **Specialty** drop-down list if the provider has more than one (1) specialty. A record is added for each specialty and selected **Servicing County**. This information is searchable on the [Health First Colorado Find a Doctor web page](#).

Click the **Add** button after each record is populated. The screen updates and adds the record. Duplicate records are not allowed. Click the **Remove** link to remove a record.

| Servicing Counties | | |
|--|---|--------|
| <p>Select the counties served for any of the provider's enrolled specialties. This field is not required.</p> <p>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.</p> | | |
| Servicing County | Specialty | Action |
| <input type="checkbox"/> Click to collapse. | | |
| *Servicing County <input type="text" value="Adams"/> | *Specialty <input type="text" value="All Specialties"/> | |
| <input type="button" value="Add"/> | | |

Servicing Counties

Select the counties served for any of the provider's enrolled specialties. 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.

| Servicing County | Specialty | Action |
|------------------|--|------------------------|
| Adams | Adpt Therapeutic Recreational Equipment/Fees - CES | Remove |
| Adams | Alternative Care Facility EBD/CMHS | Remove |
| Adams | Behavioral Programing BI | Remove |

☐ Click to collapse.

***Servicing
County**

***Specialty**

[Add](#)

Exemptions Panel

Electronic Verification Visit (EVV) providers will be presented with this panel where they may add, review and update up to 200 EVV records.

Note: Not all providers will see this panel. The Member ID must belong to a Health First Colorado member. The Electronic Visit Verification Attestation of Exemption Form is required to be completed and submitted with supporting documentation for each exemption request.

| Provider Revalidation: Exemptions | | | | | | | | | | | | | | | | | | |
|---|---|---------------|----------------|----------|--------|--|-----------|--------------|---------------|----------------|----------|--------|---|--|--|--|--|--|
| Welcome | * Indicates a required field. | | | | | | | | | | | | | | | | | |
| Request Information | Live-In Caregiver EVV Exemption Request | | | | | | | | | | | | | | | | | |
| Specialties | Refer to the EVV Program Manual web page for additional information about the EVV Exemption process, required documentation and request type options, or email evv@state.co.us to request information about EVV Exemption Pre-Approval. | | | | | | | | | | | | | | | | | |
| Addresses | 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. | | | | | | | | | | | | | | | | | |
| Provider Identification | <table border="1"> <thead> <tr> <th>Member ID</th> <th>Request Type</th> <th>Caregiver SSN</th> <th>Effective Date</th> <th>End Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6"> <input type="checkbox"/> Click to collapse. </td> </tr> </tbody> </table> | | | | | | Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | <input type="checkbox"/> Click to collapse. | | | | | |
| Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | | | | | | | | | | | | | |
| <input type="checkbox"/> Click to collapse. | | | | | | | | | | | | | | | | | | |
| Network Participation | <div> <div> *Request Type <input type="text"/> </div> <div> *Member ID <input type="text"/> </div> <div> Member First Name <input type="text"/> </div> <div> *Caregiver's First Name <input type="text"/> </div> <div> *Last 5 digits of the Caregiver SSN <input type="text"/> </div> <div> *Effective Date <input type="text"/> </div> </div> <div> <div> Member Last Name <input type="text"/> </div> <div> *Caregiver's Last Name <input type="text"/> </div> <div> *Is the Caregiver Legally Responsible for the Member? <input type="radio"/> Yes <input type="radio"/> No </div> <div> *End Date <input type="text"/> </div> </div> <div> <input type="button" value="Add"/> <input type="button" value="Reset"/> </div> | | | | | | | | | | | | | | | | | |
| Languages | | | | | | | | | | | | | | | | | | |
| Other Information | | | | | | | | | | | | | | | | | | |
| Exemptions | | | | | | | | | | | | | | | | | | |
| Disclosures | | | | | | | | | | | | | | | | | | |
| Attachments and Fees | | | | | | | | | | | | | | | | | | |
| Agreement | | | | | | | | | | | | | | | | | | |
| Summary | | | | | | | | | | | | | | | | | | |
| | <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> | | | | | | | | | | | | | | | | | |

EVV providers can add a Live-in Caregiver record to the **EVV Exemption Request** panel. Select **Live-in Caregiver** from the **Request Type** drop-down list.

| Provider Revalidation: Exemptions | | | | | | | | | | | | | | | | | | |
|---|--|---------------|----------------|----------|--------|--|-----------|--------------|---------------|----------------|----------|--------|---|--|--|--|--|--|
| Welcome | * Indicates a required field. | | | | | | | | | | | | | | | | | |
| Request Information | Live-In Caregiver EVV Exemption Request | | | | | | | | | | | | | | | | | |
| Specialties | Refer to the EVV Program Manual web page for additional information about the EVV Exemption process, required documentation and request type options, or email evv@state.co.us to request information about EVV Exemption Pre-Approval. | | | | | | | | | | | | | | | | | |
| Addresses | 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. | | | | | | | | | | | | | | | | | |
| Provider Identification | <table border="1"> <thead> <tr> <th>Member ID</th> <th>Request Type</th> <th>Caregiver SSN</th> <th>Effective Date</th> <th>End Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6"> <input type="checkbox"/> Click to collapse. </td> </tr> </tbody> </table> | | | | | | Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | <input type="checkbox"/> Click to collapse. | | | | | |
| Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | | | | | | | | | | | | | |
| <input type="checkbox"/> Click to collapse. | | | | | | | | | | | | | | | | | | |
| Network Participation | <div> <div>*Request Type</div> <div>Live-in Caregiver</div> </div> | | | | | | | | | | | | | | | | | |
| Languages | <div> <div>*Member ID</div> <div></div> </div> | | | | | | | | | | | | | | | | | |
| Other Information | <div> <div>Member First Name</div> <div>Member Last Name</div> </div> | | | | | | | | | | | | | | | | | |
| Exemptions | <div> <div>*Caregiver's First Name</div> <div>*Caregiver's Last Name</div> </div> | | | | | | | | | | | | | | | | | |
| Disclosures | <div> <div>*Last 5 digits of the Caregiver SSN</div> <div>*Is the Caregiver Legally Responsible for the Member?</div> </div> | | | | | | | | | | | | | | | | | |
| Attachments and Fees | <div> <div>*Effective Date</div> <div>End Date</div> </div> | | | | | | | | | | | | | | | | | |
| Agreement | <div> <div>Add</div> <div>Reset</div> </div> | | | | | | | | | | | | | | | | | |
| Summary | <div> <div>Continue</div> <div>Finish Later</div> <div>Cancel</div> </div> | | | | | | | | | | | | | | | | | |

Click the **Add** button after the required data is entered. The screen will update and add the selected **Request Type** to the list in the panel.

| Provider Revalidation: Exemptions | | | | | | | | | | | | | | | | | | | |
|---|---|---------------|----------------|---------------|----------------|----------|--------|--------------------|--|--|--|--|--|---|--|--|--|--|--|
| Welcome | * Indicates a required field. | | | | | | | | | | | | | | | | | | |
| Request Information | Live-In Caregiver EVV Exemption Request | | | | | | | | | | | | | | | | | | |
| Specialties | Refer to the EVV Program Manual web page for additional information about the EVV Exemption process, required documentation and request type options, or email evv@state.co.us to request information about EVV Exemption Pre-Approval. | | | | | | | | | | | | | | | | | | |
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| Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | | | | | | | | | | | | | | |
| Click to collapse. | | | | | | | | | | | | | | | | | | | |
| <div> <div>*Request Type</div> <div>Live-in Caregiver</div> </div> <div> <div>*Member ID</div> <div>G400500</div> </div> <div> <div>Member First Name</div> <div>CLIENT</div> </div> <div> <div>Member Last Name</div> <div>TEST</div> </div> <div> <div>*Caregiver's First Name</div> <div>Jane</div> </div> <div> <div>*Caregiver's Last Name</div> <div>Doe</div> </div> <div> <div>*Last 5 digits of the Caregiver SSN</div> <div>12345</div> </div> <div> <div>*Is the Caregiver Legally Responsible for the Member?</div> <div> <input checked="" type="radio"/> Yes <input type="radio"/> No </div> </div> <div> <div>*Effective Date</div> <div>03/01/2025</div> </div> <div> <div>End Date</div> <div>03/01/2026</div> </div> <div> <div>Add</div> <div>Reset</div> </div> | | | | | | | | | | | | | | | | | | | |
| Network Participation | | | | | | | | | | | | | | | | | | | |
| Languages | | | | | | | | | | | | | | | | | | | |
| Other Information | | | | | | | | | | | | | | | | | | | |
| Exemptions | | | | | | | | | | | | | | | | | | | |
| Disclosures | | | | | | | | | | | | | | | | | | | |
| Attachments and Fees | | | | | | | | | | | | | | | | | | | |
| Agreement | | | | | | | | | | | | | | | | | | | |
| Summary | | | | | | | | | | | | | | | | | | | |
| | <div>Continue</div> <div>Finish Later</div> <div>Cancel</div> | | | | | | | | | | | | | | | | | | |

To remove a record from the list on the **EVV Exemption Request** panel, click the **Remove** link in the **Action** column.

| Provider Revalidation: Exemptions | | | | | | | | | | | | | | | | | | | |
|---|--|---------------|----------------|---------------|------------------------|----------|--------|---------|-------------------|-------|------------|------------|------------------------|---------------------------------|--|--|--|--|--|
| Welcome | * Indicates a required field. | | | | | | | | | | | | | | | | | | |
| Request Information | Live-In Caregiver EVV Exemption Request | | | | | | | | | | | | | | | | | | |
| Specialties | Refer to the EVV Program Manual web page for additional information about the EVV Exemption process, required documentation and request type options, or email evv@state.co.us to request information about EVV Exemption Pre-Approval. | | | | | | | | | | | | | | | | | | |
| Addresses | 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. | | | | | | | | | | | | | | | | | | |
| Provider Identification | <table border="1"> <thead> <tr> <th>Member ID</th> <th>Request Type</th> <th>Caregiver SSN</th> <th>Effective Date</th> <th>End Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td>G400500</td> <td>Live-in Caregiver</td> <td>12345</td> <td>03/01/2025</td> <td>03/01/2026</td> <td>Remove</td> </tr> <tr> <td colspan="6">Click to add Exemption Request.</td> </tr> </tbody> </table> | Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | G400500 | Live-in Caregiver | 12345 | 03/01/2025 | 03/01/2026 | Remove | Click to add Exemption Request. | | | | | |
| Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | | | | | | | | | | | | | | |
| G400500 | Live-in Caregiver | 12345 | 03/01/2025 | 03/01/2026 | Remove | | | | | | | | | | | | | | |
| Click to add Exemption Request. | | | | | | | | | | | | | | | | | | | |
| Network Participation | | | | | | | | | | | | | | | | | | | |
| Languages | | | | | | | | | | | | | | | | | | | |
| Other Information | | | | | | | | | | | | | | | | | | | |
| Exemptions | | | | | | | | | | | | | | | | | | | |
| Disclosures | | | | | | | | | | | | | | | | | | | |
| Attachments and Fees | | | | | | | | | | | | | | | | | | | |
| Agreement | | | | | | | | | | | | | | | | | | | |
| Summary | | | | | | | | | | | | | | | | | | | |
| | <div>Continue</div> <div>Finish Later</div> <div>Cancel</div> | | | | | | | | | | | | | | | | | | |

An Extenuating Circumstances record can also be added in the **EVV Exemption Request** panel. Select **Extenuating Circumstances** from the Request Type drop-down list.

| Provider Revalidation: Exemptions | | | | | | | | | | | | | | | | | | | |
|--|---|---------------|----------------|---------------|----------------|----------|--------|---|--|--|--|--|--|--|--|--|--|--|--|
| Welcome Request Information Specialties Addresses Provider Identification Network Participation Languages Other Information Exemptions Disclosures Attachments and Fees Agreement Summary | <p>* Indicates a required field.</p> <h3>Live-In Caregiver EVV Exemption Request</h3> <p>Refer to the EVV Program Manual web page for additional information about the EVV Exemption process, required documentation and request type options, or email evv@state.co.us to request information about EVV Exemption Pre-Approval.</p> <p>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.</p> <table border="1"> <thead> <tr> <th>Member ID</th> <th>Request Type</th> <th>Caregiver SSN</th> <th>Effective Date</th> <th>End Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="6"> <input type="checkbox"/> Click to collapse. </td> </tr> <tr> <td colspan="6"> <div> <div> <p>*Request Type</p> <p>*Member ID</p> <p>Member First Name</p> <p>*Caregiver's First Name</p> <p>*Last 5 digits of the Caregiver SSN</p> <p>*Effective Date</p> </div> <div> <p>Extenuating Circumstances</p> <p></p> <p></p> <p></p> <p></p> <p></p> </div> <div> <p>Member Last Name</p> <p>*Caregiver's Last Name</p> <p>*Is the Caregiver Legally Responsible for the Member?</p> <p>*End Date</p> </div> <div> <p></p> <p></p> <p>Yes No</p> <p></p> </div> </div> <div> <p>Add Reset</p> </div> </td> </tr> </tbody> </table> <p>Continue Finish Later Cancel</p> | Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | <input type="checkbox"/> Click to collapse. | | | | | | <div> <div> <p>*Request Type</p> <p>*Member ID</p> <p>Member First Name</p> <p>*Caregiver's First Name</p> <p>*Last 5 digits of the Caregiver SSN</p> <p>*Effective Date</p> </div> <div> <p>Extenuating Circumstances</p> <p></p> <p></p> <p></p> <p></p> <p></p> </div> <div> <p>Member Last Name</p> <p>*Caregiver's Last Name</p> <p>*Is the Caregiver Legally Responsible for the Member?</p> <p>*End Date</p> </div> <div> <p></p> <p></p> <p>Yes No</p> <p></p> </div> </div> <div> <p>Add Reset</p> </div> | | | | | |
| Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | | | | | | | | | | | | | | |
| <input type="checkbox"/> Click to collapse. | | | | | | | | | | | | | | | | | | | |
| <div> <div> <p>*Request Type</p> <p>*Member ID</p> <p>Member First Name</p> <p>*Caregiver's First Name</p> <p>*Last 5 digits of the Caregiver SSN</p> <p>*Effective Date</p> </div> <div> <p>Extenuating Circumstances</p> <p></p> <p></p> <p></p> <p></p> <p></p> </div> <div> <p>Member Last Name</p> <p>*Caregiver's Last Name</p> <p>*Is the Caregiver Legally Responsible for the Member?</p> <p>*End Date</p> </div> <div> <p></p> <p></p> <p>Yes No</p> <p></p> </div> </div> <div> <p>Add Reset</p> </div> | | | | | | | | | | | | | | | | | | | |

Click the **Add** button after the required data is entered. The screen will update and add the information to a row in list on the **EVV Exemption Request** panel.

| Provider Revalidation: Exemptions | | | | | | | | | | | | | | | | | | | |
|---|---|---------------|----------------|---------------|----------------|----------|--------|---|--|--|--|--|--|---|--|--|--|--|--|
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| Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | | | | | | | | | | | | | | |
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To remove a record from the list on the **EVV Exemption Request** panel, click the **Remove** link in the **Action** column.

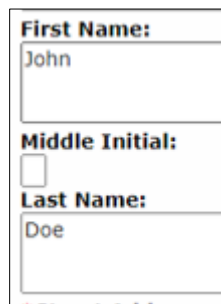
| Provider Revalidation: Exemptions | | | | | | | | | | | | | |
|--|---|---------------|----------------|---------------|------------------------|----------|--------|---|---------------------------|-------|------------|------------|------------------------|
| Welcome Request Information Specialties Addresses Provider Identification Network Participation Languages Other Information Exemptions Disclosures Attachments and Fees Agreement Summary | <p>* Indicates a required field.</p> <h3>Live-In Caregiver EVV Exemption Request</h3> <p>Refer to the EVV Program Manual web page for additional information about the EVV Exemption process, required documentation and request type options, or email evv@state.co.us to request information about EVV Exemption Pre-Approval.</p> <p>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.</p> <table border="1"> <thead> <tr> <th>Member ID</th> <th>Request Type</th> <th>Caregiver SSN</th> <th>Effective Date</th> <th>End Date</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td> <input checked="" type="checkbox"/> G400500 <input type="checkbox"/> Click to add Exemption Request. </td> <td>Extenuating Circumstances</td> <td>98765</td> <td>03/01/2025</td> <td>12/31/2025</td> <td>Remove</td> </tr> </tbody> </table> <p>Continue Finish Later Cancel</p> | Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | <input checked="" type="checkbox"/> G400500 <input type="checkbox"/> Click to add Exemption Request. | Extenuating Circumstances | 98765 | 03/01/2025 | 12/31/2025 | Remove |
| Member ID | Request Type | Caregiver SSN | Effective Date | End Date | Action | | | | | | | | |
| <input checked="" type="checkbox"/> G400500 <input type="checkbox"/> Click to add Exemption Request. | Extenuating Circumstances | 98765 | 03/01/2025 | 12/31/2025 | Remove | | | | | | | | |

Disclosures Panel

Each of the disclosures must be completed with current information.

Note the following tips when entering information in any of the disclosures:

- There is a 50-character limit in all fields. The system allows the user to enter more than 50 characters; however, this may cause system issues during processing.
- Enter organizational entities in the **Organization Name** field on one (1) line with no extra spacing or information.
 - **Example of what to enter:** ABC Company
 - **Examples of what not to enter:**
 - A B C Company
 - ABC Company (two [2] spaces between ABC and Company)
 - Company, ABC
 - ABC Company, but it used to be 123 Company before.... (add only the name of the entity, no additional information).
 - ABC
Company (two lines)
- Enter the names of individuals in the **First Name**, **Middle Initial** and **Last Name** fields. The name of the individual must be entered and cannot be a title, such as Board of Director.
 - **Example of what to enter:**



| |
|------------------------|
| First Name: |
| John |
| Middle Initial: |
| |
| Last Name: |
| Doe |

- **Example of what not to enter:**
 - John Smith (all in the same field)
 - Mr. John (do not include a prefix)
 - Smith, CEO (do not include a suffix)
 - John Smith, but it used to be owned by.... (add only the name of the entity, no additional information)

| Provider Revalidation: Disclosures ? | |
|---|---|
| Welcome | <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 through F. Answer all questions by selecting the Yes/No buttons and entering the required information in the text area. The Disclosure is incomplete if a text field is left blank, or if an entry is partially completed. |
| Request Information | |
| Specialties | |
| Addresses | |
| Provider Identification | |
| Languages | |
| Other Information | |
| Disclosures | |
| Attachments and Fees | |
| Agreement | |
| Summary | |

| 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, an officer/director of a corporation or a partner of a partnership. | 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 |
| <div> Continue Finish Later Cancel </div> | | |

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.) It is recommended to select the **No** option in the first question for individual applicants (SSN enrollments) to indicate that ownership/control interest does not apply to the individual.

Disclosures Panel – Ownership/Controlling Interest Disclosure A

| Answer Revalidation Disclosure Questions ? | | | | | | | | |
|---|--------------------|--------|---|-----------------|--------|--------------------------|--------------------|--|
| <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 § 455.106. The following disclosures must be made to Colorado Medicaid.</p> <ul style="list-style-type: none"> ▪ All entities, fiscal agents and managed care entities (see definitions) must disclose the information required in Disclosures A through F. ▪ Answer all questions by selecting the Yes/No buttons and entering the required information in the text area. The Disclosure is incomplete if a text field is left blank, or if an entry is partially completed. <p>* Indicates a required field.</p> | | | | | | | | |
| <p>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.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Disclosure Name</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/></td> <td>Click to collapse.</td> <td></td> </tr> </tbody> </table> | | | # | Disclosure Name | Action | <input type="checkbox"/> | Click to collapse. | |
| # | Disclosure Name | Action | | | | | | |
| <input type="checkbox"/> | Click to collapse. | | | | | | | |
| <p>Disclosure A Information - Ownership/Controlling Interest</p> <p>Enter the percent interest, 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 Officers and Directors. Government agencies must list board members if organized as a corporation. Additionally, corporate entities must attach a separate list of primary business address, every business location, and P.O. Box address. (Individuals enrolling/enrolled with an SSN, select "No" to question 1 to indicate there is no ownership/control interest applicable.)</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 the entity entered above an individual? <input type="radio"/> Yes <input type="radio"/> No</p> <p style="text-align: right;">Add</p> | | | | | | | | |

Selecting **Yes** opens an additional section for the required information to be entered, as shown below.

Disclosure A Information - Ownership/Controlling Interest

Enter the percent interest, 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 Officers and Directors. Government agencies must list board members if organized as a corporation. Additionally, corporate entities must attach a separate list of primary business address, every business location, and P.O. Box address. (Individuals enrolling/enrolled with an SSN, select "No" to question 1 to indicate there is no ownership/control interest applicable.)

1. ***Is there any person (individual or corporation) with an ownership or control interest in the disclosing entity as indicated above?**

☒ Yes ☐ No

***% Interest:**

15

Organization Name: (OR)

First Name:

John

Middle Initial:

Last Name:

Doe

***Street Address:**

123 Main St.

***City:**

Denver

***State:**

CO

***Zip:**

800014000

***SSN/EIN:**

123456789

2. ***Is the entity entered above an individual?**

☒ Yes ☐ No

***Date of Birth:**

07/21/1965

Add

Entities that are an individual owner must select **Yes** to question 2 (**Is the entity entered above an individual?**) and enter the individual's date of birth, as shown above. The application is returned to the user to correct the information if the user selects **No** (that the entity is not an individual) but enters information for an individual.

Click the **Add** button to update the panel as shown below when this information is complete.

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

Answer Revalidation 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 **Disclosures A through F**.
- **Answer all questions** by selecting the Yes/No buttons and entering the required information in the text area. The Disclosure is incomplete if a text field is left blank, or if an entry is partially completed.

* 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

Click the + sign next to **Click to add new Provider Disclosure** to add additional entities.

Click the **Submit** button on the right side of the panel when all ownership/controlling interest is entered. The panel updates and this item on the Disclosure list reflects **Completed**, as shown below.

Disclosures Panel – Ownership/Controlling Interest Disclosure A – Completed

| 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, an officer/director of a corporation or a partner of a partnership. | 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, Children's 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.

Clicking **Yes** opens an additional section for the required information to be entered. Click the **Add** button to update the panel when the information is completed.

Disclosures Panel – Subcontractor Ownership and Control Disclosure B - Questions

Disclosure B Information - Subcontractor Ownership and Control

Enter the percent interest, 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: (First Middle Last)**

***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. Click the **Submit** button on the right side of the panel when all subcontractor ownership and control information is entered. The panel updates and this item on the Disclosure list reflects as **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.

Clicking **Yes** opens an additional section for the required information to be entered.

Disclosures Panel – Individual Relationships Disclosure C – Questions

| Disclosure C Information - Individual Relationships | |
|--|--|
| List the name, social security number, date of birth, and relationship for any of the persons mentioned in Disclosures A and B, or persons mentioned in any other disclosing entity who are related to one another as a spouse, parent, child or sibling. | |
| 1. * Are there any persons mentioned in Disclosure A and B related to one another, or to any other person (individual or corporation) with an ownership or control interest in any other provider enrolled in the Colorado Medical Assistance Program? <input checked="" type="radio"/> Yes <input type="radio"/> No | |
| * Full Name of Person 1: <input type="text"/> | |
| * SSN: <input type="text"/> | |
| * Date of Birth: <input type="text"/> | |
| * Relationship: <input type="text"/> | |
| * Full Name of Person 2: <input type="text"/> | |
| * SSN: <input type="text"/> | |
| <input type="button" value="Add"/> | |
| <input type="button" value="Submit"/> <input type="button" value="Cancel"/> | |

Click the **Add** button to update the panel when the information is completed.

Continue to add individuals as applicable. Click the **Submit** button on the right side of the panel when all individual relationships are entered. The panel updates and this item on the Disclosure list now reflects as completed.

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

Clicking **Yes** opens an additional section for the required information to be entered. Click the **Add** button to update the panel when the information is completed.

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. | |
| <div style="background-color: #0070C0; color: white; padding: 5px; text-align: center;"> Disclosure D Information - Managing Individuals </div> <p>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".</p> <p>1. *Is there any person who holds a position of managing employee as outlined above? <input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*First Name: <input type="text"/></p> <p>Middle Initial: <input type="text"/></p> <p>*Last Name: <input type="text"/></p> <p>*SSN: <input type="text"/></p> <p>*Date of Birth: <input type="text"/></p> <p>*Street Address: <input type="text"/></p> <p>*City: <input type="text"/></p> <p>*State: <input type="text"/></p> <p>*Zip: <input type="text"/></p> <p style="text-align: right;">Add</p> | | |

Continue to add individuals as applicable. Click the **Submit** button on the right side of the panel when all managing individuals are entered. The panel updates and this item on the Disclosure list now reflects as 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.

Clicking **Yes** opens an additional section for the required information to be entered. Click the **Add** button to update the panel when the information is completed.

Disclosures Panel – Business Relationships Disclosure E– Questions

Disclosure E Information - Business Relationships
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".
1. ***Is there any individual with an ownership or control interest as outlined above?**
☒ Yes ☐ No
% Interest:

***Full Name of Provider: (First Middle Last)**

SSN:
Date of Birth:
***Full Name Other Provider:**

SSN/EIN:

2. ***Is there any business, organization or corporation with an ownership or control interest as outlined above?**
☒ Yes ☐ No
% Interest:

***Full Name of Provider:**

EIN:

***Full Name Other Provider:**

SSN/EIN:

Continue to add entities as applicable. Click the **Submit** button on the right side of the panel when all business relationships are entered. The panel updates and this item on the Disclosure list now reflects as 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

| 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?</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Full Name:</p> <div></div> <p>*SSN/EIN:</p> <div></div> <p>*Offense:</p> <div></div> <p>*Conviction Date: </p> <div></div> <p>*Jurisdiction:</p> <div></div> | |
| <p>2. *Is the entity entered above an individual?</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>*Date of Birth: </p> <div></div> | |
| <div>Add</div> | |
| <div>Submit Cancel</div> | |

Clicking **Yes** opens an additional section for the required information to be entered. Click the **Add** button to update the panel when the information is completed.

Continue to add entities as applicable. Click the **Submit** button on the right side of the panel when all convictions are entered. The panel updates and this item on the Disclosure list now reflects as completed.


Click **Continue**, **Finish Later** or **Cancel** when all questions have been completed within the **Disclosures** panel.

Disclosures Panel – Completed

| 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, an officer/director of a corporation or a partner of a partnership. | 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, Children's Health Insurance Program or the Title XX services since the inception of these programs. | Completed |
| <div> Continue Finish Later Cancel </div> | | |

Fingerprinting Panel

The **Fingerprinting** panel displays if the provider's Revalidation Risk Level is **High**, and fingerprints are required for each individual owner listed with an ownership of 5% or more. Owner information is populated by the content entered on the **Disclosures** panel. For providers that are business entities, all owners with 5% or more interest in the business is displayed with a status indicating any individuals that need to submit fingerprints.

ent: 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 |

Continue **Finish Later** **Cancel**

Owners that have **not** completed the Fingerprinting and Criminal Background Check (for either **Medicare** or **Medicaid**) must follow the instructions on this panel to have fingerprints submitted within 30 calendar days of the submission of the revalidation application.

Refer to the information in the Fingerprinting drop-down under Enrollment Facts on the [Provider Enrollment web page](#).

ent: 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**

Owners that **have** completed the Fingerprinting and Criminal Background Check (for either **Medicare** or **Medicaid**) should select **Yes** next to the appropriate selection. The panel updates after **Yes** is selected and requests confirmation of the state in which the fingerprinting was completed. Select the checkbox next to the acknowledgement statement.

ent: 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).

Save
Reset
Cancel

Continue
Finish Later
Cancel

Click **Save** once completed with **each owner**, then click **Continue** to move to the next section.

Providers and owners requiring fingerprinting are given specific instructions on how to proceed once the application is submitted.

Attachments and Fees Panel

| Provider Revalidation: Attachments And Fees ? | | | | | | | | | | | | | | | | | | | |
|--|---|------|-----------------|--------|---|---------------------|------|-----------------|--------|---|--|--|--|--|---|--|--|--|--|
| Welcome Request Information Specialties Addresses Provider Identification Network Participation Languages Other Information Exemptions Disclosures ▶ Attachments and Fees Agreement Summary | Supporting Documentation <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 W-9 Form (if applicable)</p> <p>Submit as Attachment: Completed Supervising Physician Signature Form (if applicable)</p> <p>Submit as Attachment: License (if applicable)</p> <p>* Indicates a required field.</p> | | | | | | | | | | | | | | | | | | |
| | Revalidation Attachments | | | | | | | | | | | | | | | | | | |
| | <p>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.</p> <p>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.</p> <p>Click the Remove link to remove the entire row.</p> <table border="1"> <thead> <tr> <th>#</th> <th>Transmission Method</th> <th>File</th> <th>Attachment Type</th> <th>Action</th> </tr> </thead> <tbody> <tr> <td colspan="5"> <input type="checkbox"/> Click to collapse. </td> </tr> <tr> <td colspan="5"> <div> <div>*Transmission Method</div> <div>FT-File Transfer ▼</div> </div> <div> <div>*Upload File</div> <div> <input type="button" value="Choose File"/> No file chosen </div> </div> <div> <div>*Attachment Type</div> <div> <input type="text"/> ▼ </div> </div> <div> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </div> </td> </tr> </tbody> </table> | | | | # | Transmission Method | File | Attachment Type | Action | <input type="checkbox"/> Click to collapse. | | | | | <div> <div>*Transmission Method</div> <div>FT-File Transfer ▼</div> </div> <div> <div>*Upload File</div> <div> <input type="button" value="Choose File"/> No file chosen </div> </div> <div> <div>*Attachment Type</div> <div> <input type="text"/> ▼ </div> </div> <div> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </div> | | | | |
| # | Transmission Method | File | Attachment Type | Action | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Click to collapse. | | | | | | | | | | | | | | | | | | | |
| <div> <div>*Transmission Method</div> <div>FT-File Transfer ▼</div> </div> <div> <div>*Upload File</div> <div> <input type="button" value="Choose File"/> No file chosen </div> </div> <div> <div>*Attachment Type</div> <div> <input type="text"/> ▼ </div> </div> <div> <input type="button" value="Add"/> <input type="button" value="Cancel"/> </div> | | | | | | | | | | | | | | | | | | | |
| | Application Fee <div>No Application Fee Required</div> | | | | | | | | | | | | | | | | | | |
| | <div> <input type="button" value="Continue"/> <input type="button" value="Finish Later"/> <input type="button" value="Cancel"/> </div> | | | | | | | | | | | | | | | | | | |

Attachments Section

Attachments and Fees

Revalidation Attachments

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

| # | Transmission Method | File | Attachment Type | Action |
|---|---------------------|------|-----------------|--------|
| Click to collapse. | | | | |
| <p>*Transmission Method FT-File Transfer</p> <p>*Upload File Choose File No file chosen</p> <p>*Attachment Type </p> | | | | |
| <p>Add Cancel</p> | | | | |

Click the + sign to add each attachment as needed. Click the **Remove** link to remove an attachment. Click **Continue**, **Finish Later** or **Cancel** once all attachments are added.

Attachments and Fees

Revalidation Attachments

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

| # | Transmission Method | File | Attachment Type | Action |
|--------------------------|---------------------|---------------------|-----------------|------------------------|
| 1 | FT-File Transfer | Email74889.txt (1K) | Other | Remove |
| Click to add attachment. | | | | |

Required attachments may be submitted electronically on this panel. Attachments sent by mail, email or fax cannot be accepted. These attachments must be added to the **Attachments and Fees** panel of the revalidation application.

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

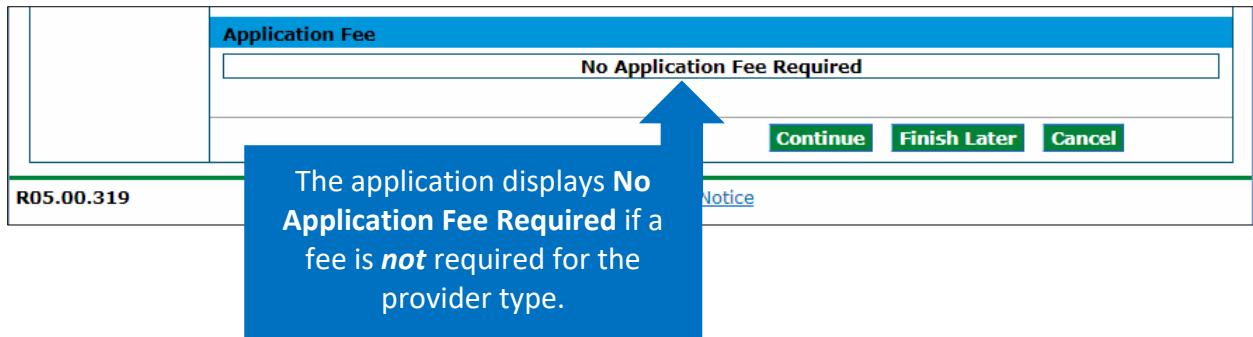
A current copy is required if any of the following information is added or updated in the revalidation application:

- 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 questions in the **Application Fee** section are displayed only when applicable. The application fee may not be required for revalidation if the service location has enrolled or revalidated with Medicare or another state's Medicaid program in the last five (5) years and paid an application fee. A copy of the receipt indicating payment to another state Medicaid agency must be uploaded in the **Attachments** section with an **Attachment Type** of **Other**.

The application fee is set annually by the Centers for Medicare & Medicaid Services (CMS). The updated fee begins on January 1 and ends on December 31 each year. Visit the [Provider Enrollment web page](#) for the current amount.

Attachments and Fees Panel – No Fee Required

The screenshot shows a web interface for the Attachments and Fees Panel. A blue callout box with an arrow pointing to the 'No Application Fee Required' text states: 'The application displays No Application Fee Required if a fee is *not* required for the provider type.' The interface includes a header 'Application Fee', a text box containing 'No Application Fee Required', and buttons for 'Continue', 'Finish Later', and 'Cancel'. A status bar at the bottom left shows 'R05.00.319' and a 'Notice' link is visible on the right.

Attachments and Fees Panel – Fee Required

The screenshot shows a web interface for the Attachments and Fees Panel. A blue callout box with an arrow pointing to the 'Amount Due' section states: 'This panel displays if a fee *is* required for the provider type.' The interface includes a header 'Amount Due XXX.00', a bullet point 'To make a payment, click the link below.' with a link 'Online Bill Pay', and buttons for 'Continue', 'Finish Later', and 'Cancel'.

Financial Hardship

Users requesting a waiver for financial hardship must 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 of Health Care Policy & Financing (the Department) and Centers for Medicare & Medicaid Services (CMS) in the determination.

- Recommended supporting documentation includes most recent entity tax return(s), financial profit/loss exports (i.e., QuickBooks, Xero, etc.), three (3) or more bank statements and any additional documentation that would validate the hardship(s) indicated within the hardship letter.
 - Additional supporting documentation may include but is not limited to historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, liability obligations, tax returns, etc.






The revalidation will be delayed while a determination is made if the user applies for an application fee waiver. The letter and supporting documentation must be uploaded on this panel in the **Attachments** section with an **Attachment Type** of **Other**.

Click the **Online Bill Pay** link if an application fee is due, and a payment form opens 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

*Card Expiration Date

*Verification Code

*Billing Address Zip Code

Payment Amount \$ XXX.XX

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

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

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

All Provider Participation Agreements (PPAs) must be read and accepted before submitting the revalidation application.

| Provider Revalidation: Agreement | |
|---|---|
| Welcome | Instructions |
| Request Information | The terms of revalidation are stated below. The provider must accept these terms 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 | Once the application is submitted and confirmed, a tracking number will be assigned. Print a copy of the tracking number and application for your records. |
| Provider Identification | |
| Languages | |
| Other Information | |
| Disclosures | Terms of Agreement |
| Attachments and Fees | <p>Provider Name CMHC PAYER</p> <p>Address 321 DENVER Colorado, 88888-8888</p> <p>Tax ID 358709870</p> <p>NPI 1073029971</p> <p>Contact Name TEST TEST</p> <p>Contact Email test@test.com</p> <p>No provider application, enrollment form, provider authorization form (if applicable), or Provider Participation Agreement (PPA) will be processed without completion of this page.</p> <p>Read and print the PPA(s) for your records. The PPA applies to all programs and payers.</p> <p>Note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until all applicable PPAs have been read.</p> <p>Read and Print: Colorado BHA Provider Participation Agreement</p> <p>Read and Print: Title XIX Payer Provider Participation Agreement</p> <p><input checked="" type="checkbox"/> I accept the Colorado BHA PPA</p> <p><input checked="" type="checkbox"/> I accept the Title XIX Payer PPA</p> <p>Note: The provider must review the applicable PPAs 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"/></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 04/10/2023</p> |
| Agreement | |
| Summary | |



A checkmark appears next to the PPA link once complete.

Enter the provider's name as the electronic signature and select the **I accept** box to complete the panel. The **Review** button becomes active.

Summary Panel

The **Summary** panel shows the revalidation application in its entirety. The user should review all information for accuracy.

| Provider Revalidation: Summary ? | | | | | | | | | | | | | | | | | | | | |
|---|---|--------------------|----------------|------------|--------------|--------------------|--------------------|----------------------------------|---|-----------------------|------------|---------------|----------------------------------|------------------|-----------------------|-----------|----------------------------------|------------------|------------|----------|
| Welcome Request Information Specialties Addresses Provider Identification Languages Other Information Disclosures Attachments and Fees Agreement Summary | Request Information <div> Revalidation Effective Date 08/02/2023 Enrollment Type Group Provider Type Clinic - Practitioner </div> <div> Provider Federal Tax Identification Number (TIN) 456789123 Effective Date 06/13/2023 End Date 12/31/2299 Fiscal End Date _ </div> <div> NPI 1235318346 MCD 9000177714 NPI Zip + 4 88888-8888 Taxonomy 193200000X-Multi-Specialty </div> <div> Contact Name TEST TEST Contact Phone 1-529-896-4641 Ext _ Contact Email test@test.com Preferred Method of Communication Email Email For Provider Publications test1@test.com </div> | | | | | | | | | | | | | | | | | | | |
| | Addresses Expand All Collapse All | | | | | | | | | | | | | | | | | | | |
| | <table border="1"> <thead> <tr> <th>Address Type</th> <th>Address</th> <th>City</th> <th>State</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Service Location</td> <td>123 EVERGREEN RD</td> <td>DENVER</td> <td>Colorado</td> </tr> <tr> <td><input type="checkbox"/> Billing</td> <td>123 EVERGREEN RD</td> <td>DENVER</td> <td>Colorado</td> </tr> <tr> <td><input type="checkbox"/> Mailing</td> <td>123 EVERGREEN RD</td> <td>DENVER</td> <td>Colorado</td> </tr> </tbody> </table> | | | | Address Type | Address | City | State | <input type="checkbox"/> Service Location | 123 EVERGREEN RD | DENVER | Colorado | <input type="checkbox"/> Billing | 123 EVERGREEN RD | DENVER | Colorado | <input type="checkbox"/> Mailing | 123 EVERGREEN RD | DENVER | Colorado |
| Address Type | Address | City | State | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Service Location | 123 EVERGREEN RD | DENVER | Colorado | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Billing | 123 EVERGREEN RD | DENVER | Colorado | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Mailing | 123 EVERGREEN RD | DENVER | Colorado | | | | | | | | | | | | | | | | | |
| | Specialties <div> <input checked="" type="checkbox"/> Specialty Clinic - Practitioner Taxonomy Multi-Specialty Effective Date 05/20/2023 - 12/31/2299 </div> <div> Additional Taxonomies Registered Nurse - Diabetes Educator </div> | | | | | | | | | | | | | | | | | | | |
| | Provider Identification <div> Gender _ Birth Date _ </div> <div> Provider Name TEST Business Name PHYSICIAN </div> <div> Organization Type Estate Other, please explain _ </div> | | | | | | | | | | | | | | | | | | | |
| | <div> Payer Title XIX Payer Medicare # _ Effective Date _ Medicare Type _ </div> <div> NCPDP Provider ID Number _ Pharmacy Classification _ </div> | | | | | | | | | | | | | | | | | | | |
| | Languages <table border="1"> <thead> <tr> <th>Language</th> <th>Proficiency</th> </tr> </thead> <tbody> <tr> <td>English</td> <td>Professional Working Proficiency</td> </tr> </tbody> </table> | | | | Language | Proficiency | English | Professional Working Proficiency | | | | | | | | | | | | |
| Language | Proficiency | | | | | | | | | | | | | | | | | | | |
| English | Professional Working Proficiency | | | | | | | | | | | | | | | | | | | |
| | Malpractice/General Liability Insurance <div> No Malpractice/General Liability Insurance exist for this application </div> | | | | | | | | | | | | | | | | | | | |
| | Certification <table border="1"> <thead> <tr> <th>Specialty</th> <th>Certificate Number</th> <th>Certification Type</th> <th>Effective Date</th> <th>End Date</th> </tr> </thead> <tbody> <tr> <td>Clinic - Practitioner</td> <td>1546465216</td> <td>Accreditation</td> <td>02/12/2022</td> <td>06/12/2022</td> </tr> <tr> <td>Clinic - Practitioner</td> <td>986264621</td> <td>Foster Care Home</td> <td>01/02/2023</td> <td>06/12/2023</td> </tr> </tbody> </table> | | | | Specialty | Certificate Number | Certification Type | Effective Date | End Date | Clinic - Practitioner | 1546465216 | Accreditation | 02/12/2022 | 06/12/2022 | Clinic - Practitioner | 986264621 | Foster Care Home | 01/02/2023 | 06/12/2023 | |
| Specialty | Certificate Number | Certification Type | Effective Date | End Date | | | | | | | | | | | | | | | | |
| Clinic - Practitioner | 1546465216 | Accreditation | 02/12/2022 | 06/12/2022 | | | | | | | | | | | | | | | | |
| Clinic - Practitioner | 986264621 | Foster Care Home | 01/02/2023 | 06/12/2023 | | | | | | | | | | | | | | | | |

| | <div style="background-color: #e1f5fe; padding: 5px;">Medicaid Participation</div> <ol style="list-style-type: none"> 1. Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)? 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)? 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)? 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? 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? No 6. Have you ever been excluded from participation in federal procurement? No 7. Do you hold all licenses and certifications as required based on your provider type? Yes 8. Is this license expired, or subject to conditions or restrictions? No 9. Have you ever been subject to a payment suspension based on a credible allegation of fraud? 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? No <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">Website Address _</div> | | | | | | | | | | | | | | | | | | | | | |
|--|---|-----------------|-------------|--------|--|--|-----------|--|---|-----------|---|---|-----------|---------------------------------------|---|-----------|---|--|-----------|--|---|-----------|
| | <div style="background-color: #00bcd4; color: white; padding: 5px;">Disclosures</div> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #bbdefb;"> <th style="text-align: left; padding: 5px;">Disclosure Name</th> <th style="text-align: left; padding: 5px;">Description</th> <th style="text-align: left; padding: 5px;">Status</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">A. OWNERSHIP OR CONTROL INTEREST</td> <td style="padding: 5px;">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, an officer/director of a corporation or a partner of a partnership.</td> <td style="padding: 5px;">Completed</td> </tr> <tr> <td style="padding: 5px;">B. SUBCONTRACTOR OWNERSHIP</td> <td style="padding: 5px;">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.</td> <td style="padding: 5px;">Completed</td> </tr> <tr> <td style="padding: 5px;">C. INDIVIDUAL RELATIONSHIPS</td> <td style="padding: 5px;">Persons mentioned in Disclosure A and Disclosure B related to one another as a spouse, parent, child, or sibling.</td> <td style="padding: 5px;">Completed</td> </tr> <tr> <td style="padding: 5px;">D. MANAGING EMPLOYEES</td> <td style="padding: 5px;">Persons who hold a position of managing employee within the disclosing entity, fiscal agent or managed care entity.</td> <td style="padding: 5px;">Completed</td> </tr> <tr> <td style="padding: 5px;">E. BUSINESS RELATIONSHIPS</td> <td style="padding: 5px;">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.</td> <td style="padding: 5px;">Completed</td> </tr> <tr> <td style="padding: 5px;">F. CONVICTIONS OF CRIMINAL OFFENSE</td> <td style="padding: 5px;">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.</td> <td style="padding: 5px;">Completed</td> </tr> </tbody> </table> | 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, an officer/director of a corporation or a partner of a partnership. | 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, Children's Health Insurance Program or the Title XX services since the inception of these programs. | Completed |
| 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, an officer/director of a corporation or a partner of a partnership. | 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 | | | | | | | | | | | | | | | | | | | | |
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| |
|---|
| 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 W-9 Form (if applicable) |
| 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) |
| No Revalidation Attachments exist for this application |
| Application Fee |
| No Application Fee Required |
| Terms of Agreement |
| No provider application, enrollment form, provider authorization form (if applicable), or Provider Participation Agreement (PPA) will be processed without completion of this page. |
| Read and print the PPA(s) for your records. The PPA applies to all programs and payers. |
| Note that the Acceptance checkbox in the Terms of Agreement section at the bottom of the page will remain disabled until all applicable PPAs have been read. |
| Read and Print: Title XIX Payer Provider Participation Agreement |
| 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. |
| I understand that my electronic signature is equivalent to written signature. |
| Your Signature test |
| (Entering your name in the box to the right will constitute your electronic signature.) |
| Suffix _ |
| Agreement Date 08/02/2023 |

| |
|--|
| Instructions for Summary Page |
| 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. |
| Print Preview Submit Finish Later Cancel |

Click the **Print Preview** button to print a copy of the revalidation application. This is the only opportunity to print a copy.

Click the **Submit** button to submit the revalidation application for review. Click the **Finish Later** button to save the information and finish the application later. Click the **Cancel** button to log out of the application without saving the information.

When the **Submit** button is clicked, the user is asked if they have printed a copy of this application for their records. Click **OK** if a copy has been printed or the user does not wish to print a copy. The user may click **Cancel** to return to the application to print a copy.

Submit Complete Application

Have you printed a copy for your records? Select OK to submit the application or select Cancel if you need to return to application to print a copy.

OK Cancel

Clicking the **OK** button displays the tracking number for the revalidation application.

The screenshot shows the Colorado Department of Health Care Policy & Financing (HCPF) website. The header includes the HCPF logo, the text "COLORADO Department of Health Care Policy & Financing", and the "Health First COLORADO" logo with the tagline "Colorado's Medicaid Program". Navigation links include "Home", "Eligibility", "Claims", "Care Management", and "Resources". A breadcrumb trail shows the path: Home > Provider Revalidation > Revalidation Summary > Revalidation Tracking Information. The date and time are displayed as Monday 04/06/2020 04:10 PM MST.

Provider information is displayed in a blue box:

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

A "Print Preview" button is located to the right of the provider information.

The main content area is titled "Provider Revalidation: Tracking Information" and contains the following text:

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.*

An "Exit" button is located at the bottom right of the content area.

Click the **Exit** button to return to the **Welcome** panel.

Contact the [Provider Services Call Center](#) for additional support.

Visit the [For Our Providers web page](#) for additional resources.

Resume Revalidation

Log in to the Provider Web Portal and click the **Revalidation** link to:

- Open the revalidation application and resume the revalidation process if the user was unable to complete the process and elected to save the work.
- Access the revalidation application if the application was completed but the user received a Return to Provider (RTP) email from the fiscal agent stating additional or corrected information is needed.

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!

Contact Us

Notify Me

Alerts

Secure Correspondence

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

No changes may be made to the information entered once the application is submitted unless the revalidation application is RTP'd for updates or corrections.

Revalidation Status

Click the **Revalidation** link to open the **Provider Revalidation Status** panel if the application has been submitted for review.

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

Search 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 notes display here indicating the application needs to be RTP'd, the user **cannot** access the application to make corrections until the status reads one of the following:

- Returned to Provider for Additional Information
- Returned to Provider for Additional Authorization(s)
- Returned to Provider for Missing Documentation

A notification email is sent to the contact email address from the application to notify of the status once the revalidation application is returned.

Click the **Revalidation** link, then click the **Revise Revalidation Application** link if the status indicates corrections are needed. This link displays only when the application is returned for corrections.

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

[Search](#) [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 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](#)

Site Visits

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

The purpose is to verify that the information submitted to the Department by a provider is accurate and to determine compliance with federal and state enrollment requirements. The user is contacted for the required site visit if the provider type falls into one of these risk categories. 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.

Refer to the risk levels on the [Provider Type Information for Revalidation web page](#) for further information about risk categories by provider type.

Provider Revalidation Notifications

The provider receives several email notifications during the revalidation process which are 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 contact the provider directly with questions about the revalidation application.

- An email notification is sent during the revalidation review process to the email address entered in the contact information if additional information and/or missing documentation is needed. The applicant is then able to return to the revalidation application by logging in to the Provider Web Portal and clicking the **Revalidation** link. The fiscal agent is notified once this is complete and will continue processing.
- An email notification is sent to the address entered in the contact information advising the applicant of the outcome once the application is reviewed.
 - The user is advised if the revalidation application is approved.

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 |
| 3/10/2022 | Updated for Provider Identification Panel update | 14-17 | Gainwell Technologies |
| 9/26/22 | Updated screenshots | 14-16, 23-36 | Gainwell Technologies |
| 01/31/2023 | Updated two graphics for 2023 application fee | 39 - 40 | Gainwell Technologies |
| 02/16/2023 | Updated browser name Updated verbiage and three graphics for Provider Identification, Agreement, Summary panels Updated graphic for Disclosures panel | 2 12, 41-42, 46-47 45 | Gainwell Technologies |
| 04/05/2023 | Updated button verbiage and graphic (Completing the Revalidation Application) Updated Provider Web Portal link Added Tracking Information section Updated Cancel button verbiage Updated Provider Enrollment Portal link | 5-6 6 10 47 53 | Gainwell Technologies |
| 06/15/2023 | Updated graphic panels: Provider Identification Agreement Terms of Agreement | 13 42, 43 48 | Gainwell Technologies |

| Revision Date | Section/Action | Pages | Made by |
|---------------|---|------------------------------|-----------------------|
| 08/10/2023 | Added graphic for Certification panel (Provider Identification Panel) 3rd bullet, verbiage added for Certification record 2nd bullet, removed (Other Information Panel), 2 nd paragraph removed certification information verbiage Added graphic for Provider Revalidation: Summary (Summary Panel) | 16 17 24 46, 47 | Gainwell Technologies |
| 08/24/2023 | Updated screenshots Added Department of Regulatory Agencies (DORA) license information | 14-16 17 | Gainwell Technologies |
| 12/14/2023 | Updated screen shots/information for Language and Address panels Updated screen shots to make application fee amounts generic | 19, 39-41 44 | Gainwell Technologies |
| 02/23/2024 | Updated screen shots/language | 19 | Gainwell Technologies |
| 04/18/2024 | Updated screen shots/language Added Financial Hardship information | 26-30 47 | Gainwell Technologies |
| 07/25/2024 | Removed filing a grievance information Updated taxonomies in Request Information Panel section | 52-56 8-9 | Gainwell Technologies |
| 8/6/2024 | Left-aligned all text and images for accessibility purposes | All | Gainwell Technologies |
| 9/19/2024 | Added information on Substance Use Disorder Bed Count Panel | 20-22 | Gainwell Technologies |
| 10/31/2024 | Updated for Doing Business As Name for SCR 48861 | 12, 15-16 | Gainwell Technologies |
| 03/06/2025 | Added Exemptions Panel information for SCR 56883.01 | 31-35 | Gainwell Technologies |