COLORADO
Department of Health Care Policy & Financing

Provider Revalidation Manual

Table of Contents

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 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. If the user is new to the enrollment process, it will be helpful to review the Provider Enrollment Manual 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

To navigate through the revalidation application in the Provider Web Portal, please have the latest version of one of the following web browsers installed on the personal computer (PC).

- Microsoft Edge
- Mozilla Fire Fox
- Safari

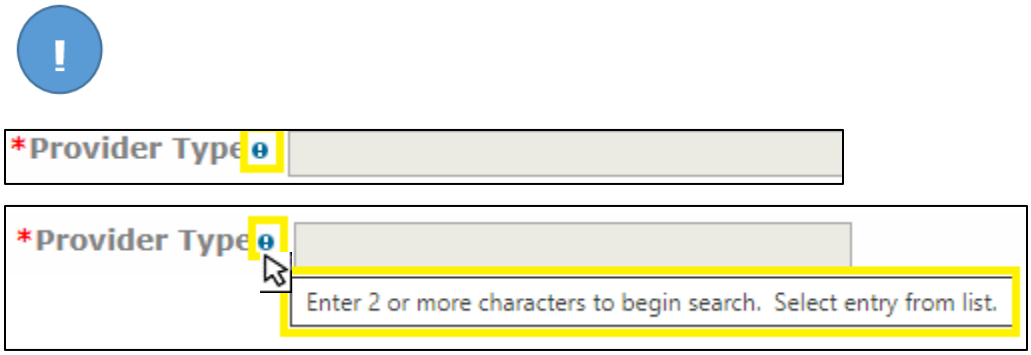
- Google Chrome

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

More Information on a Field

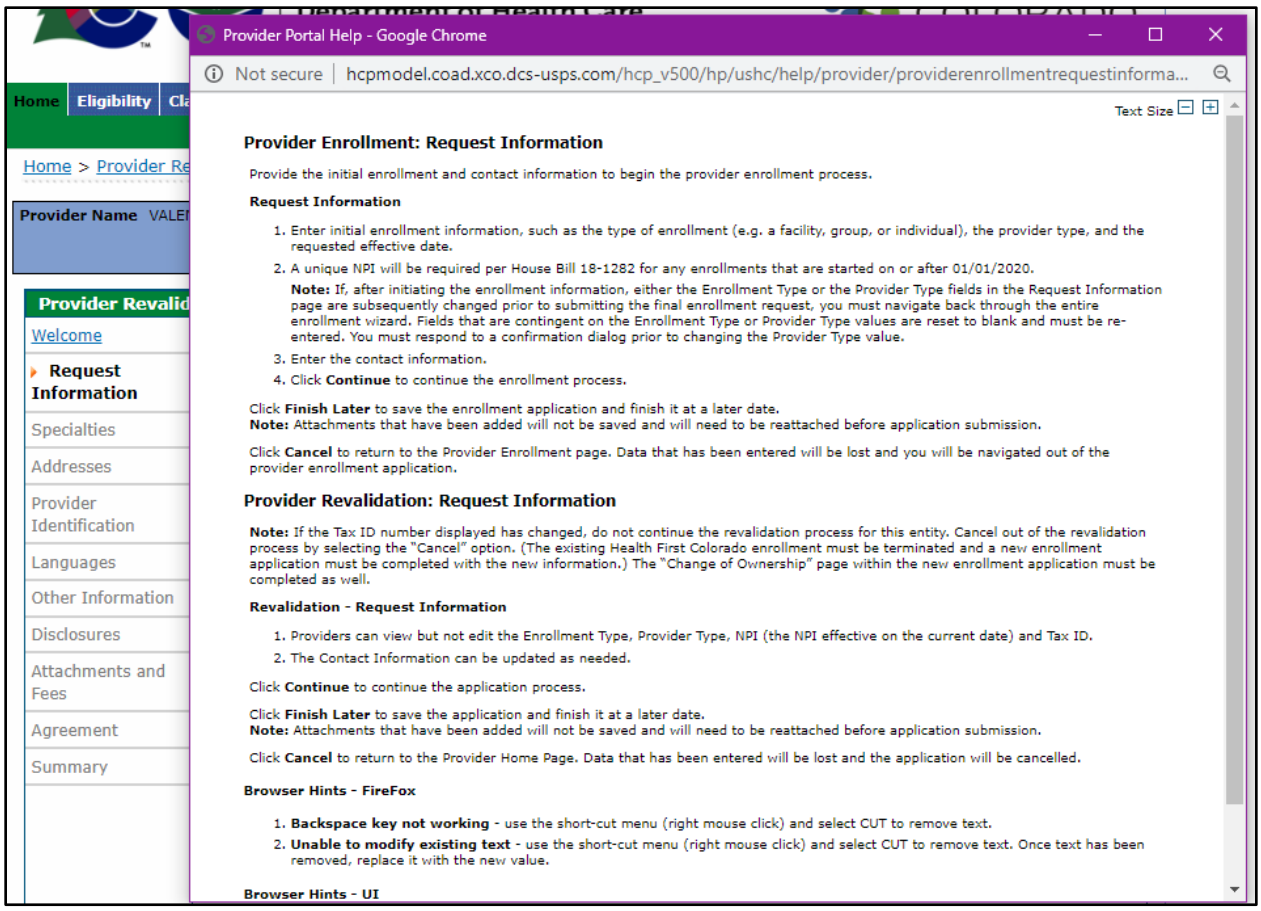
Throughout the Revalidation process a red asterisk * next to a field indicates that it is required information.
Note: panels with fields that display an asterisk may not be applicable for some Provider Type/Specialty combinations. These fields can be left blank for those providers. However, if data is entered in one of the fields, then all the fields with an asterisk must be completed.

In certain fields, additional information can be found by hovering the cursor over the exclamation point. Hovering over this will open a gray box that gives more information about the field. The gray information box will disappear when the cursor is moved.



Help Feature on Each Page

Throughout the revalidation process there is a question mark symbol towards the top right corner of each page. Clicking on it will open a dialog help window specific to the screen the user is currently in:



Key Facts

Prior to beginning the revalidation process, having the following information available will help make the process quicker. **Additional requirements will vary depending on the provider type & enrollment type.**

Please visit the Revalidation Information by Provider Type 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 statements are sent if the provider is not receiving them electronically.

License Number (if applicable) – This is the identification number assigned by licensing agencies. Be sure to enter all alphanumeric characters, dots and dashes of the license number and attach a copy.

Certification Information (if applicable) – This is for any additional certifications the provider would like included in the profile. Be sure to include all alphanumeric characters of the certificate number and attach a copy.

Malpractice & Liability Insurance Information – Complete the insurance information.

Ownership/Controlling Interest & Conviction Disclosure Information

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, the following information is needed:

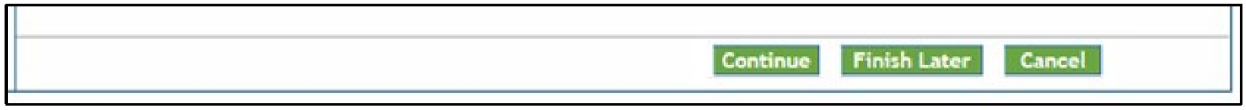
- Name
- Address
- Federal Employer ID Number (EIN) or Social Security Number (SSN) - for individuals
- Date of birth (DOB) if individual

For more information, please review the Disclosure Instructions located on the Department's website under Provider Forms then Provider Enrollment & Update Forms.

- Disclosure Instructions SSN (colorado.gov)
- Disclosure Instructions EIN (colorado.gov)

Completing the Revalidation Application

The Provider Web Portal utilizes an autosave feature to automatically save entered data in the revalidation process. While completing the application, the user will see three buttons available at the bottom of each panel.

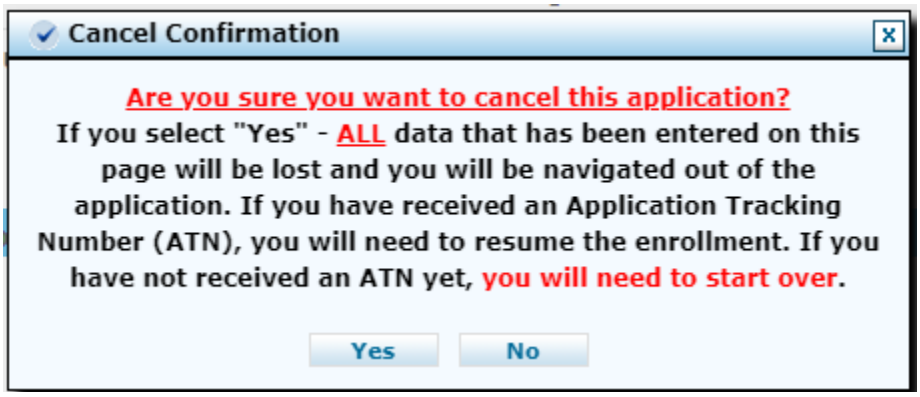


These buttons allow the user to:

Continue – Continue 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 will automatically save the data entered on the current panel.

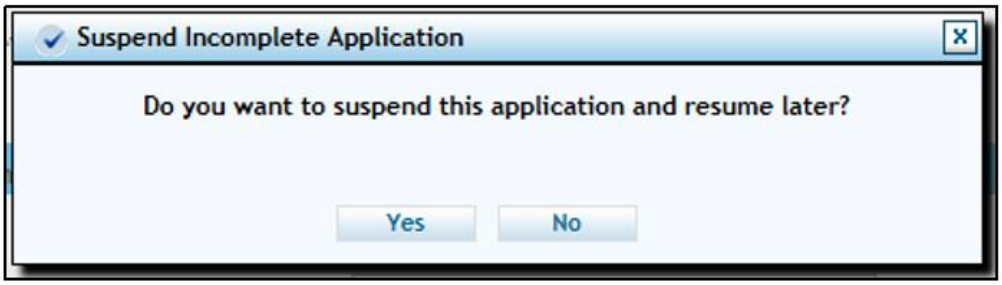
Cancel – Stops the application. If an Application Tracking Number (ATN) has been generated, this button will prompt the end of the application process without saving the data on the current panel (data entered on prior panels has already been saved). If an ATN has not been generated yet, clicking this button will prompt the end of the application process without saving the data. Please note that a confirmation notification to cancel will appear before the user is permitted to proceed.

The Cancel Confirmation screen shown below will appear. If "**Yes**" is selected, all data entered on this and any previous panels will be lost if an ATN has not been generated.



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

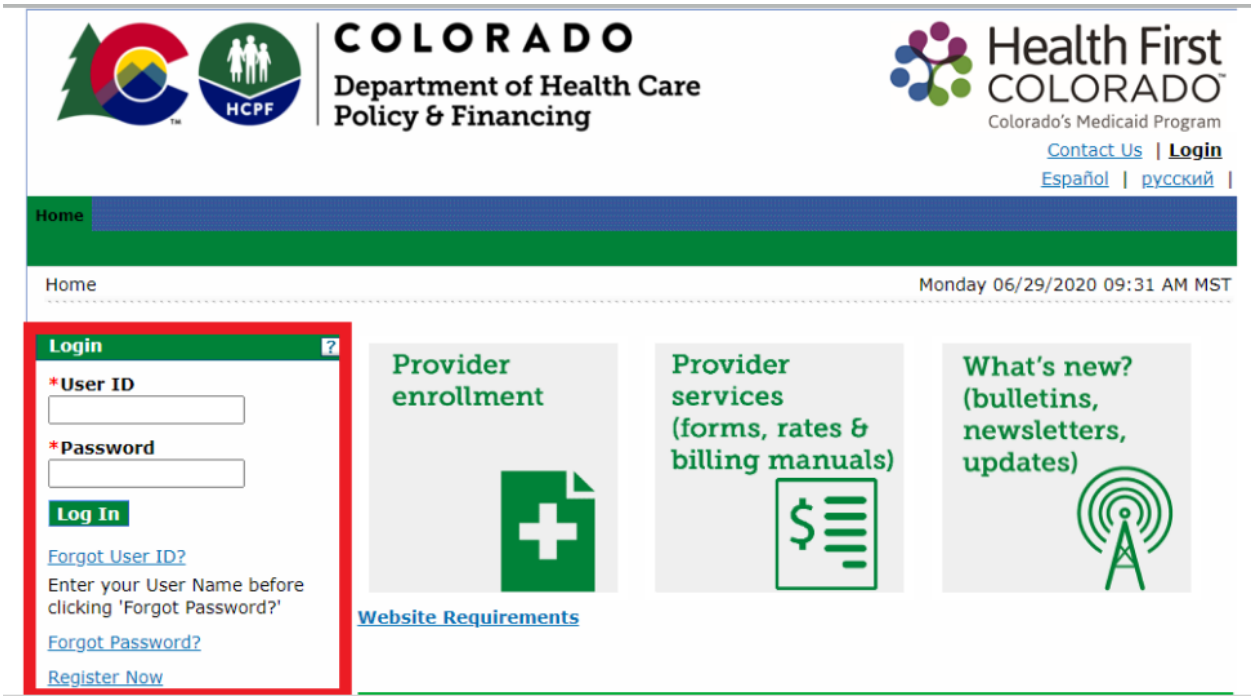
Suspend Incomplete Application Pop Up



Select “No” and the user will return to the application process. Select “Yes” and you will be logged out of the Revalidation application and assigned a tracking number to the Revalidation application. **It is important to retain the application tracking number (ATN) for future use.**

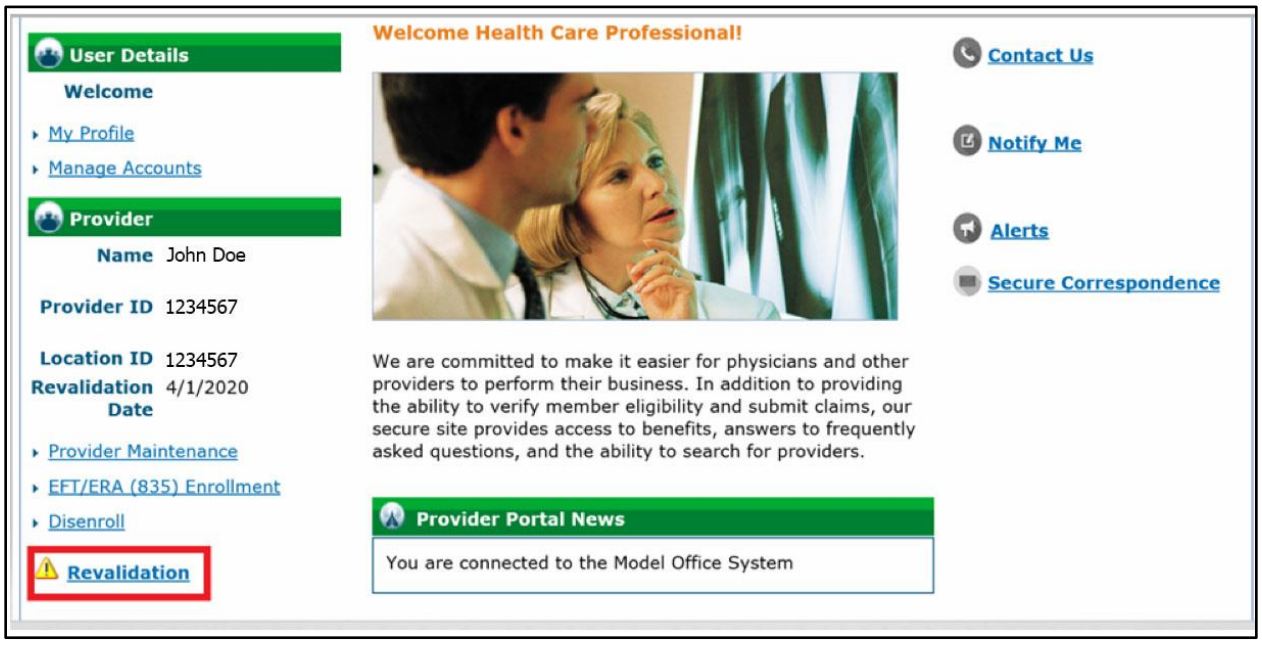
Accessing the Provider Web Portal

Login to Provider Web Portal.



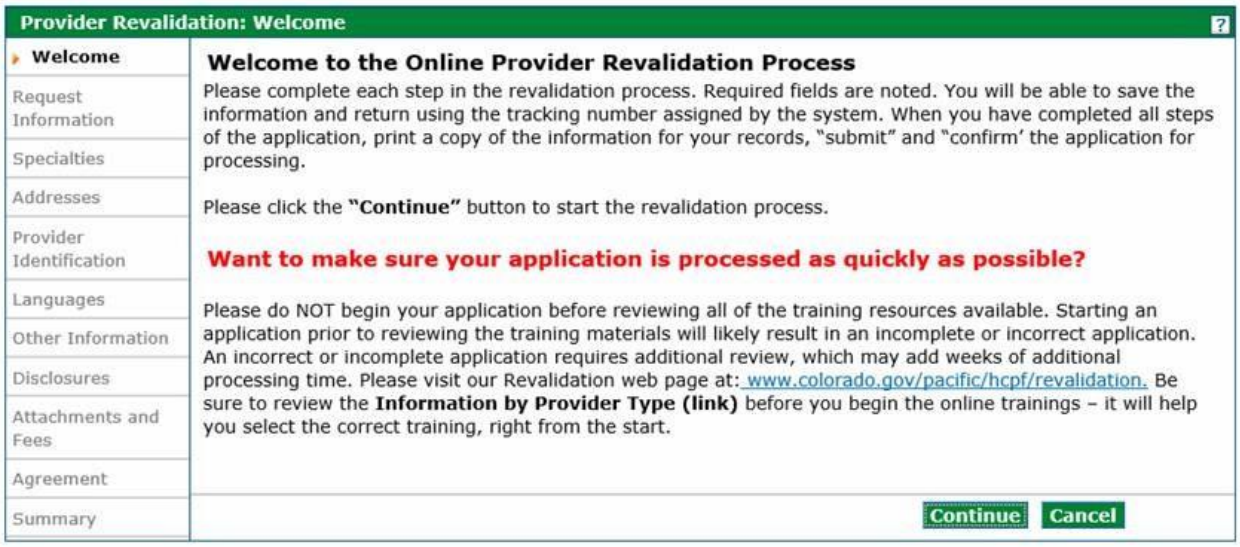
Click "Revalidation" as shown in the next screenshot.

The date that displays next to the "Revalidation Date" field is the date that the provider is due to complete revalidation.



This will direct providers to the **Welcome** panel of revalidation.

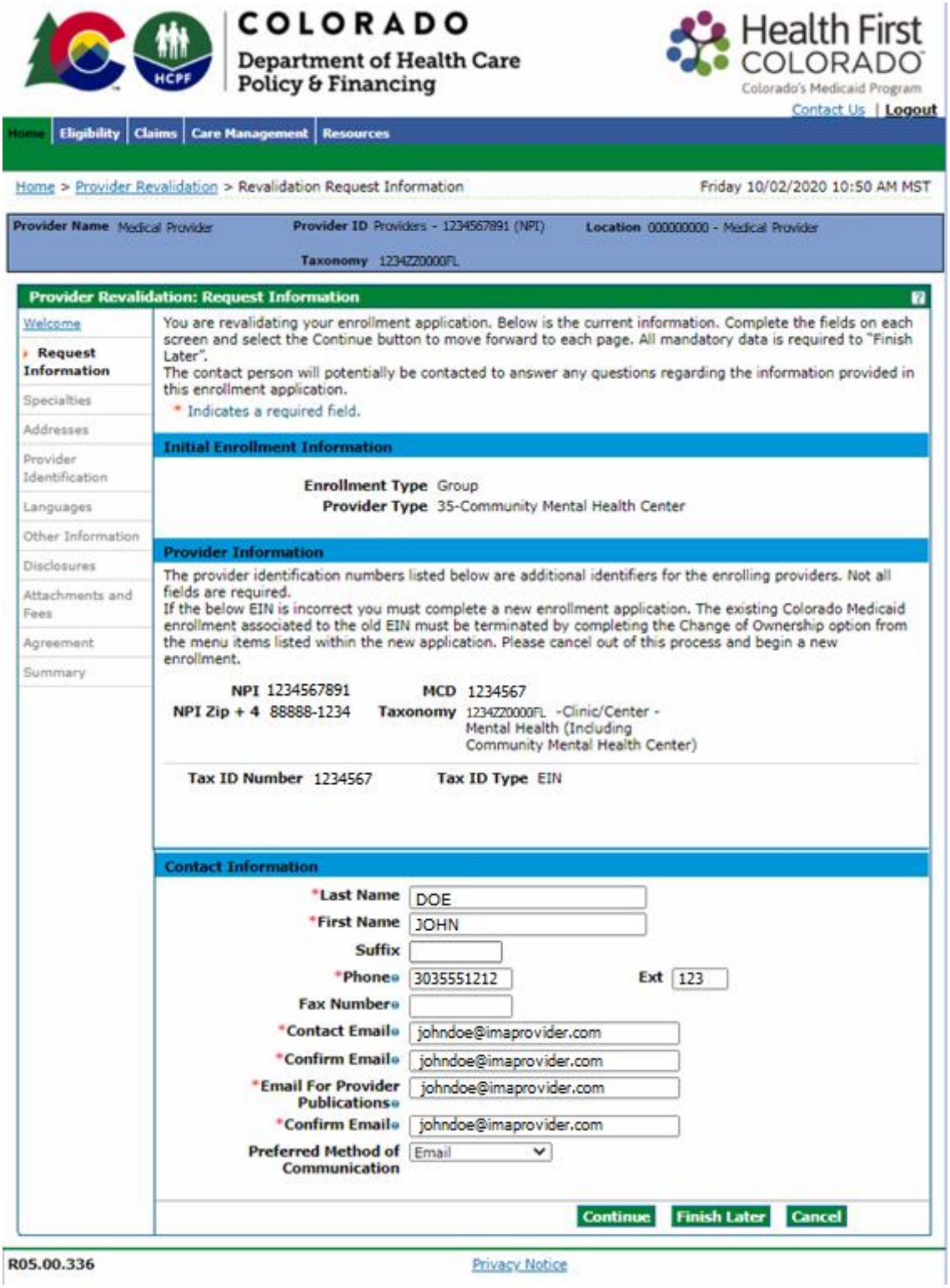
Welcome Panel



Once the information has been reviewed, click the “Continue” button to start Revalidation.

Request Information Panel

After clicking the “Continue” button, the Request Information Panel will be displayed.


COLORADO
Department of Health Care Policy & Financing
Health First COLORADO
Colorado's Medicaid Program
Contact Us | Logout
Home | Eligibility | Claims | Care Management | Resources
Home > Provider Revalidation > Revalidation Request Information
Friday 10/02/2020 10:50 AM MST
Provider Name Medical Provider
Provider ID Providers - 1234567891 (NPI)
Location 00000000 - Medical Provider
Taxonomy 1234ZZ0000FL
Provider Revalidation: Request Information
Welcome
Request Information
Specialties
Addresses
Provider Identification
Languages
Other Information
Disclosures
Attachments and Fees
Agreement
Summary
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".
The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application.
* Indicates a required field.
Initial Enrollment Information
Enrollment Type Group
Provider Type 35-Community Mental Health Center
Provider Information
The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.
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.
NPI 1234567891
MCD 1234567
NPI Zip + 4 88888-1234
Taxonomy 1234ZZ0000FL -Clinic/Center - Mental Health (Including Community Mental Health Center)
Tax ID Number 1234567
Tax ID Type EIN
Contact Information
*Last Name DOE
*First Name JOHN
Suffix
*Phone 3035551212
Ext 123
Fax Number
*Contact Email johndoe@imaprovider.com
*Confirm Email johndoe@imaprovider.com
*Email For Provider Publications johndoe@imaprovider.com
*Confirm Email johndoe@imaprovider.com
Preferred Method of Communication Email
Continue
Finish Later
Cancel
R05.00.336
Privacy Notice

Within this panel the provider must verify that contact information is current, and if necessary, update the information. This is the contact person who may be contacted to answer questions regarding the Revalidation application.

Fields that are view only:

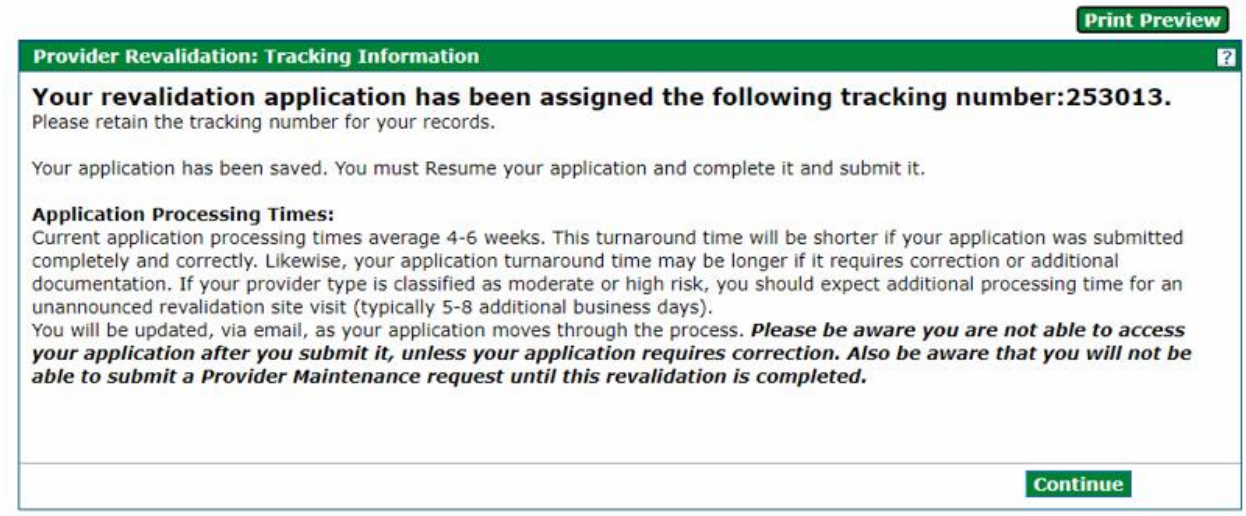
- Provider's NPI
- Medicaid ID (MCD)
- NPI Zip +4
- Taxonomy
- Tax ID Number
- Tax ID type (EIN or SSN)

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

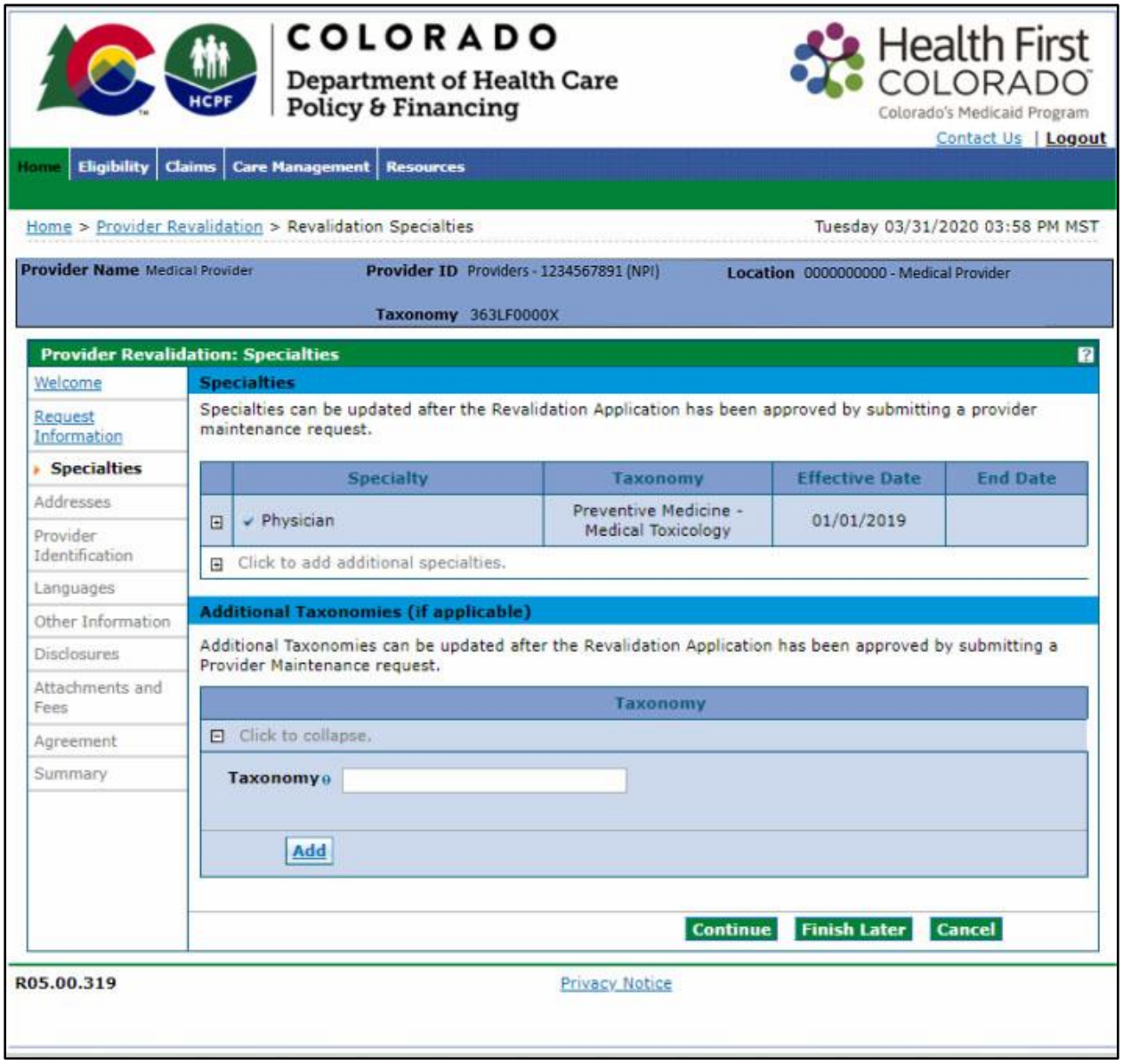
If the Tax ID is a Social Security Number (SSN) and there is another actively enrolled provider in the system with the same SSN, the user will not be able to continue with the revalidation process. Individuals (SSNs) are limited to one (1) enrollment.

Tracking Information

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

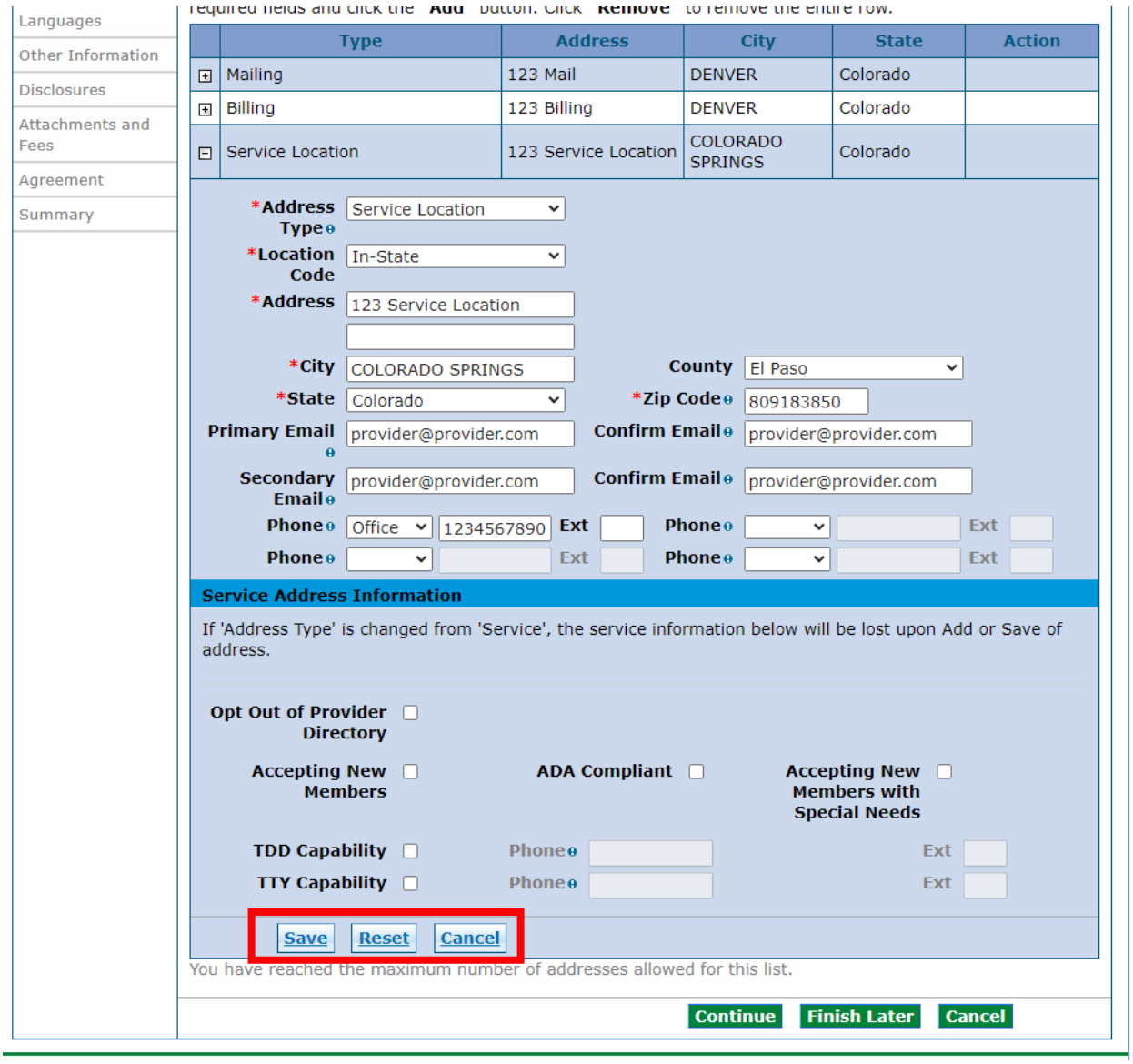


Specialties Panel



Specialties and Additional Taxonomies may not be updated during revalidation. Specialties and Additional Taxonomies may be added with a separate maintenance request after the revalidation is completed.

Addresses Panel



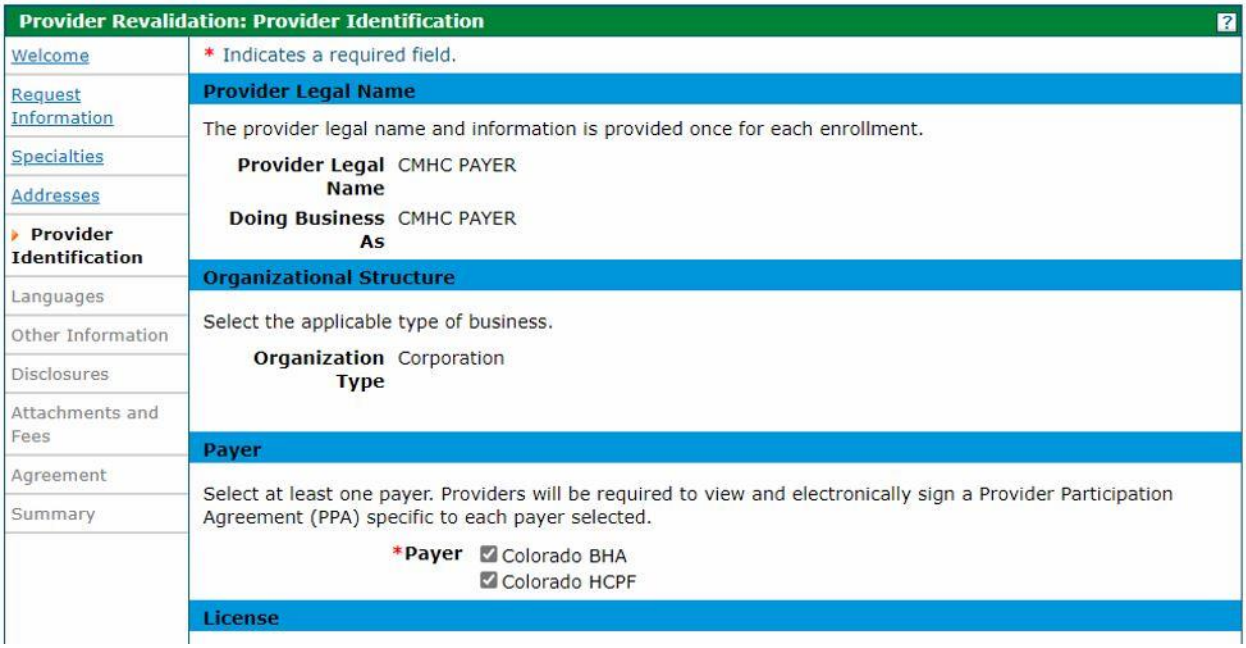
Within this panel the provider may update:

- Service Location
- Billing Address
- Mailing Address

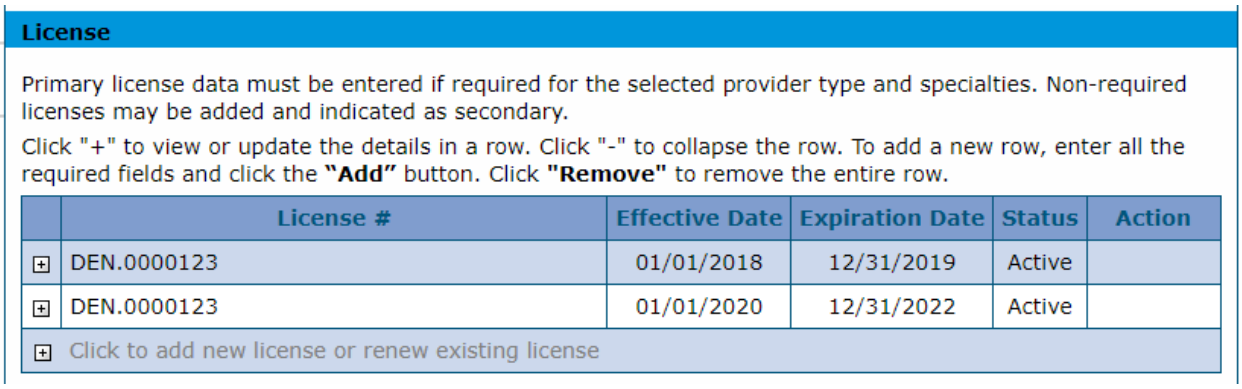
If updating the Service Location, Billing or Mailing address, select the drop-down to update the information. Select “Save” to save the updated information. Select “Reset” to refresh the information. Select ”Cancel” to cancel the update within this section.

Provider Identification Panel

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



Initial view of licenses (nothing is expanded):



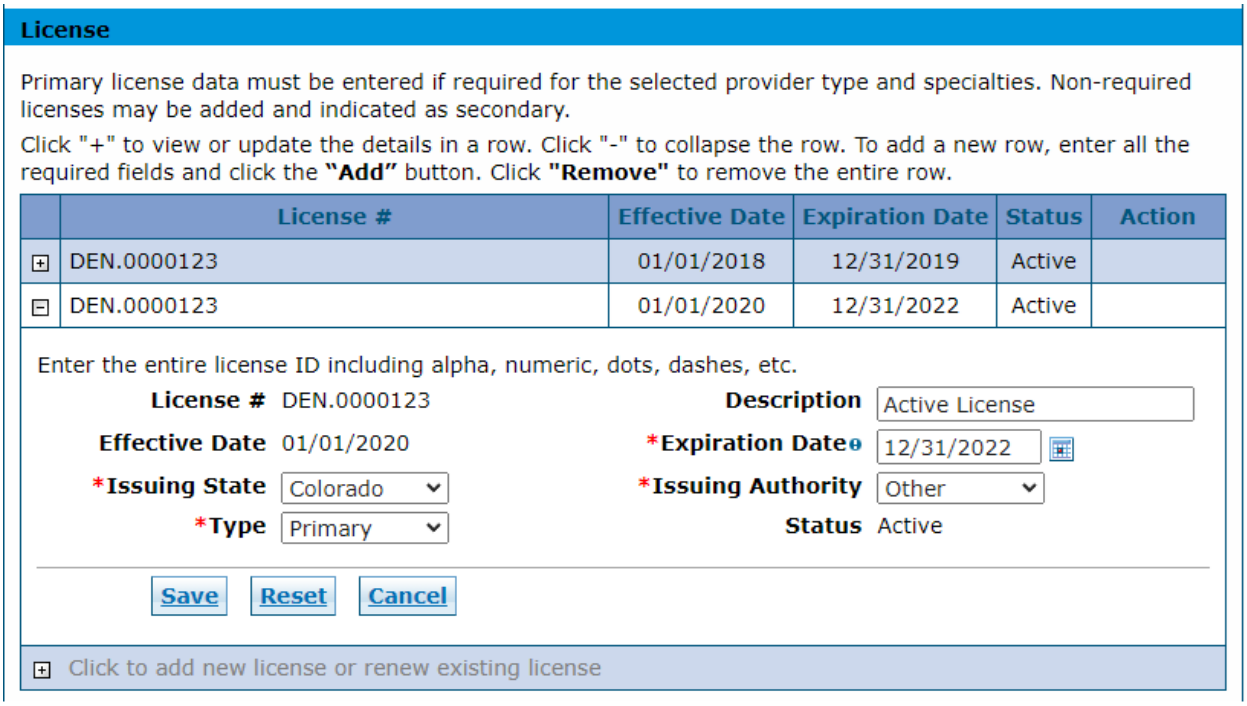
License

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 "+" 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	12/31/2019	Active	
⊞	DEN.0000123	01/01/2020	12/31/2022	Active	
⊞	Click to add new license or renew existing license				

Expanded view of a license record:



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 "+" 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	12/31/2019	Active	
⊟	DEN.0000123	01/01/2020	12/31/2022	Active	

Enter the entire license ID including alpha, numeric, dots, dashes, etc.

License # DEN.0000123 **Description** Active License

Effective Date 01/01/2020 ***Expiration Date** 12/31/2022

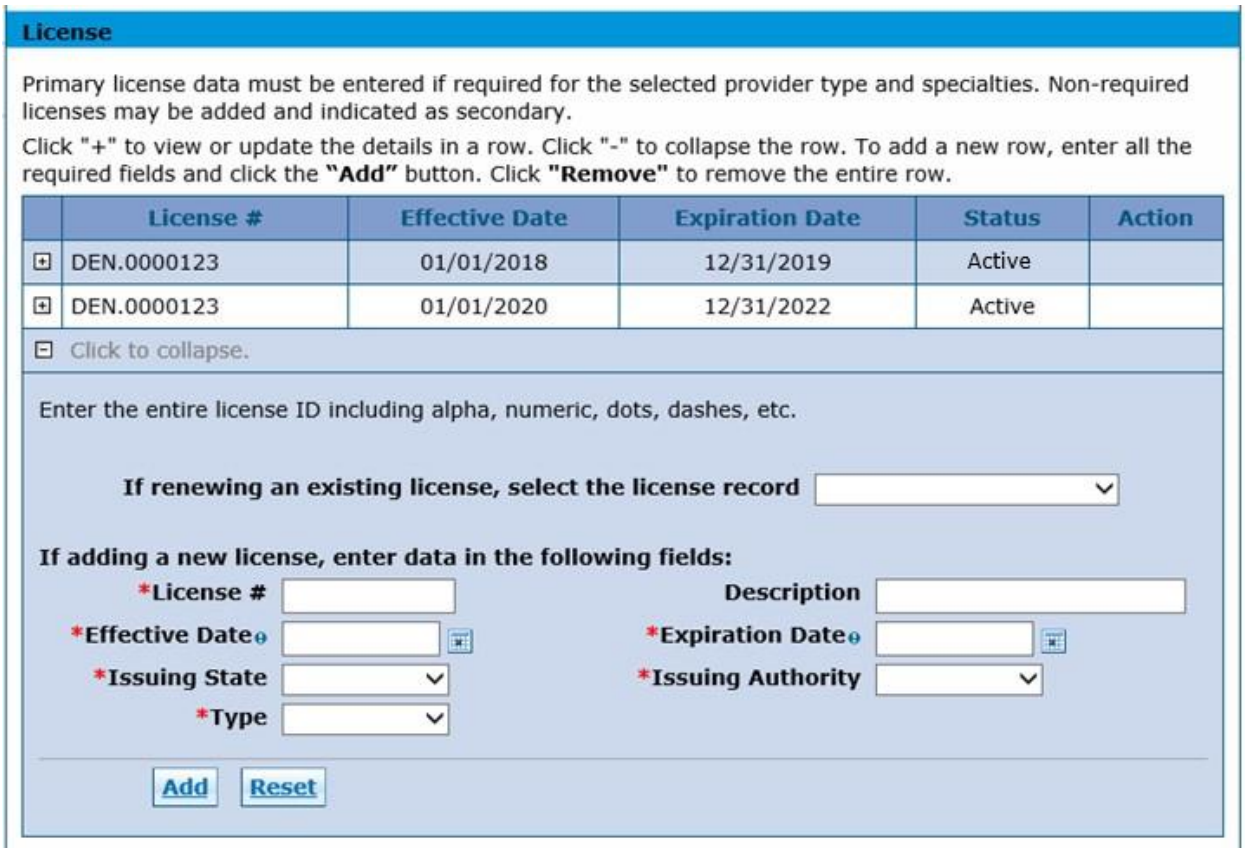
***Issuing State** Colorado ***Issuing Authority** Other

***Type** Primary **Status** Active

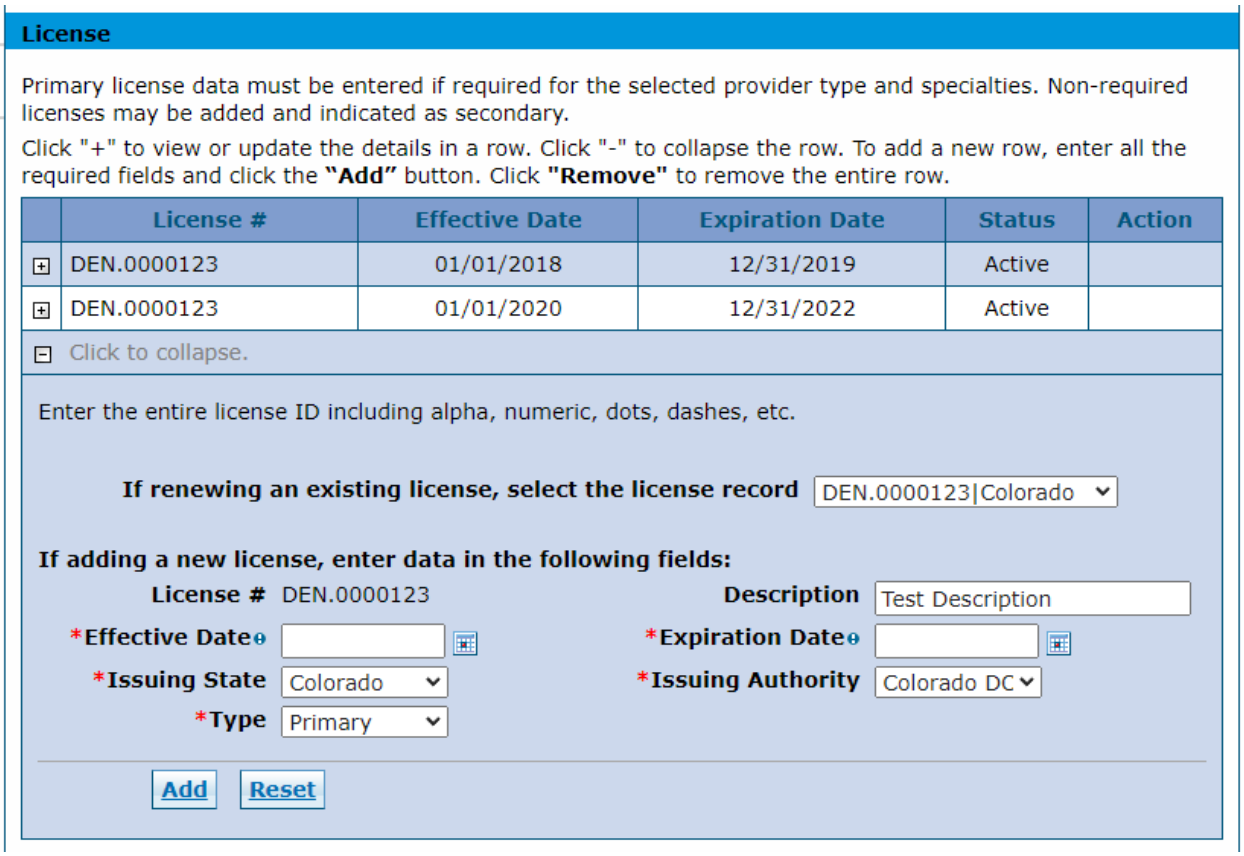
Save Reset Cancel

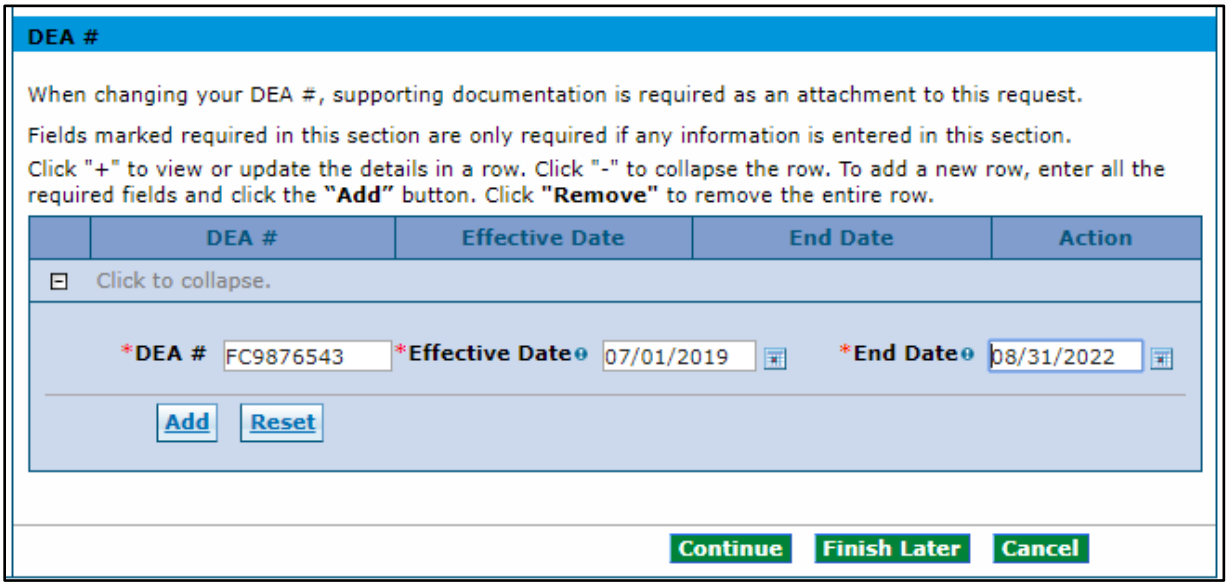
⊞ Click to add new license or renew existing license

Adding a new license with a different number:



Renewing an existing license with the same number:





Within this panel the provider is able to:

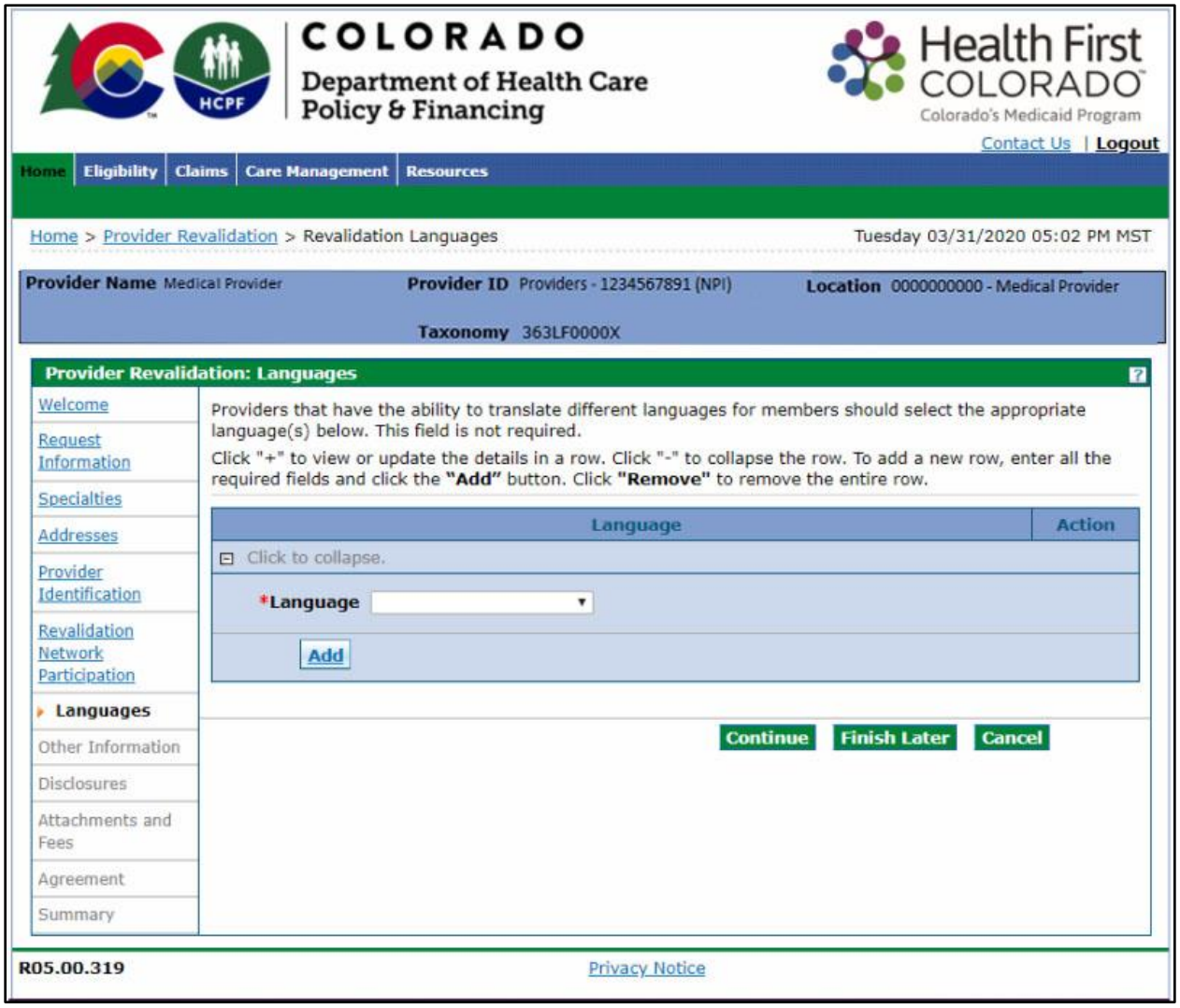
- Add new license information or renew an existing license (if applicable). Be sure to enter all alphanumeric characters, dots and dashes.
- Review and update the Expiration Date for an existing license.
  NOTE: If updating an existing license, the expiration date can be changed to an earlier date, it cannot be extended. Extending the expiration date is considered a renewal.
- Review and update 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.

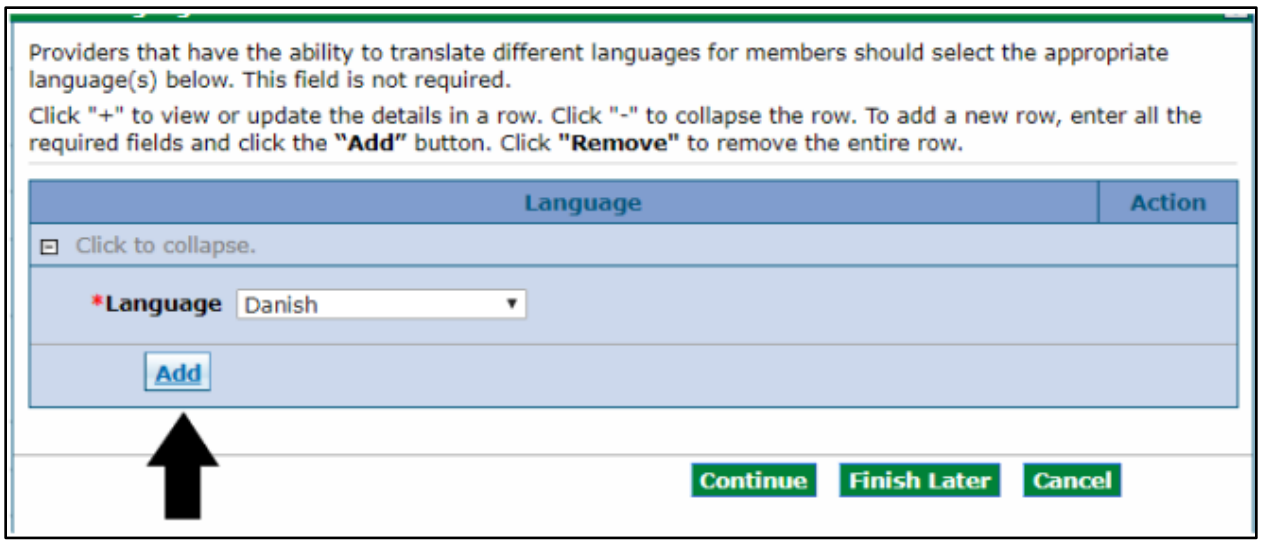
Fields that are view only:

- Provider Legal Name
- Doing Business As name
- Organization Type
- Existing license information (excluding the Expiration Date field)
- Expired license information
- Existing DEA license information (excluding the End Date field)

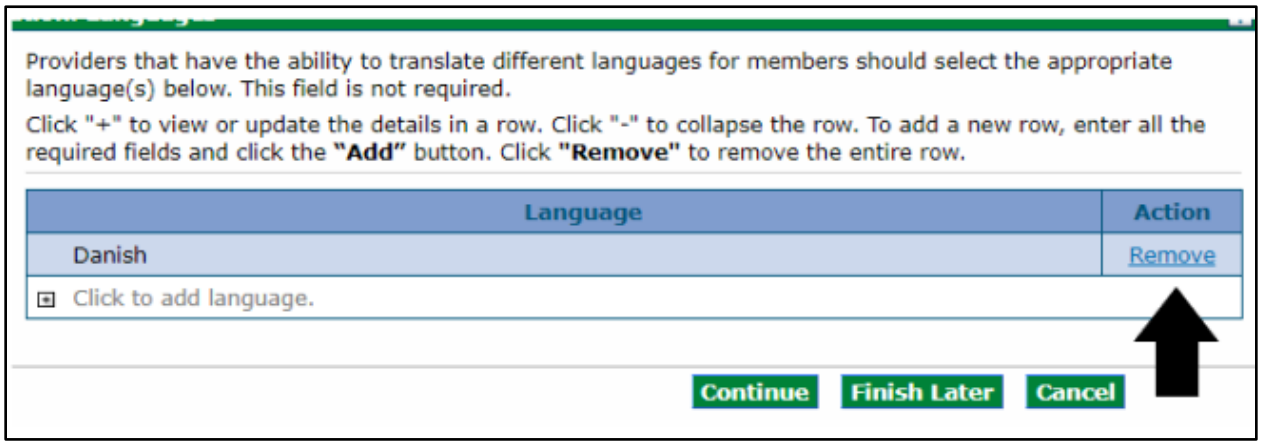
Languages Panel



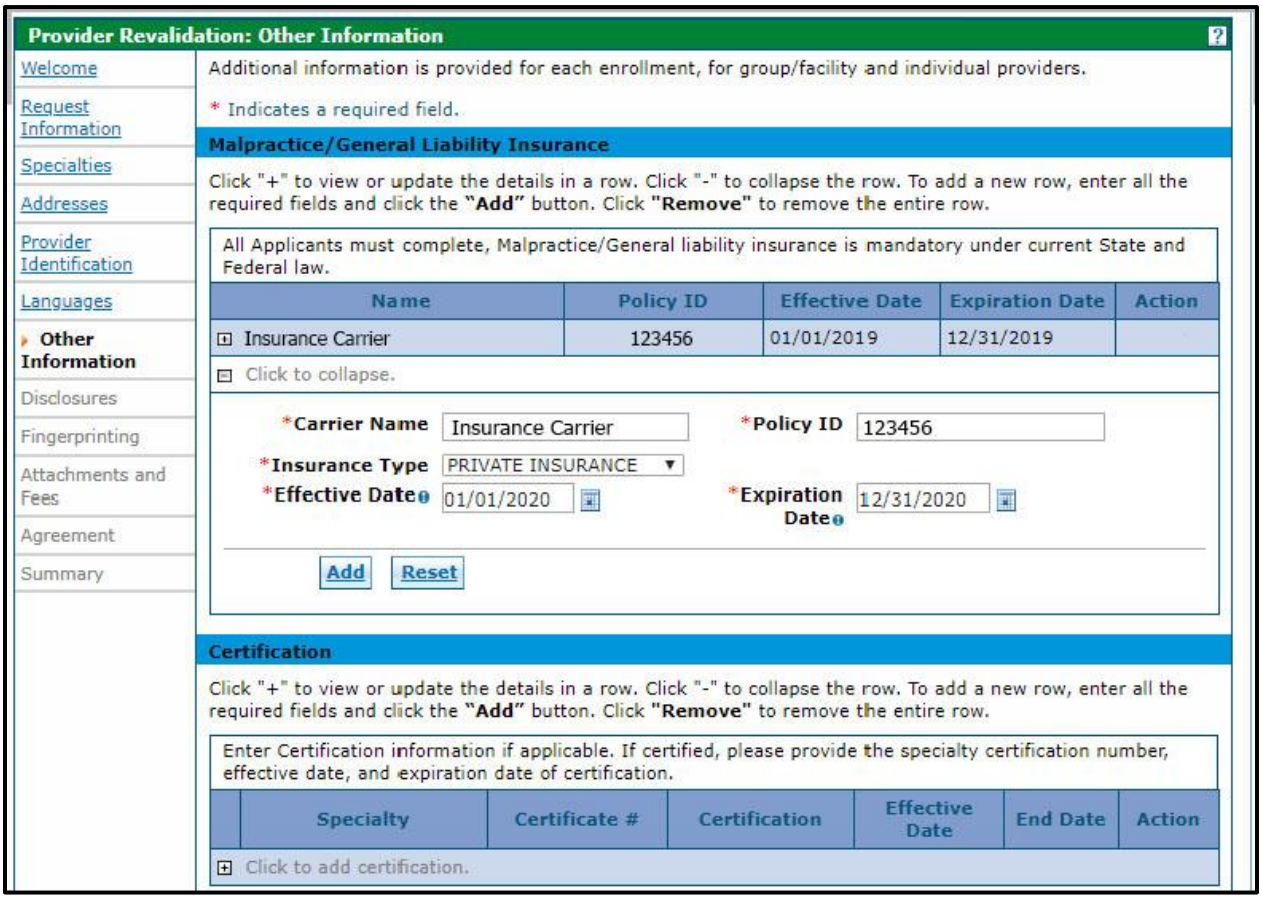
Within this panel the provider may review and update the languages spoken within the office or facility. There are currently 60 languages available to choose from. After each language is selected, click the “Add” button. The screen will update and add the selected item to the list of languages.

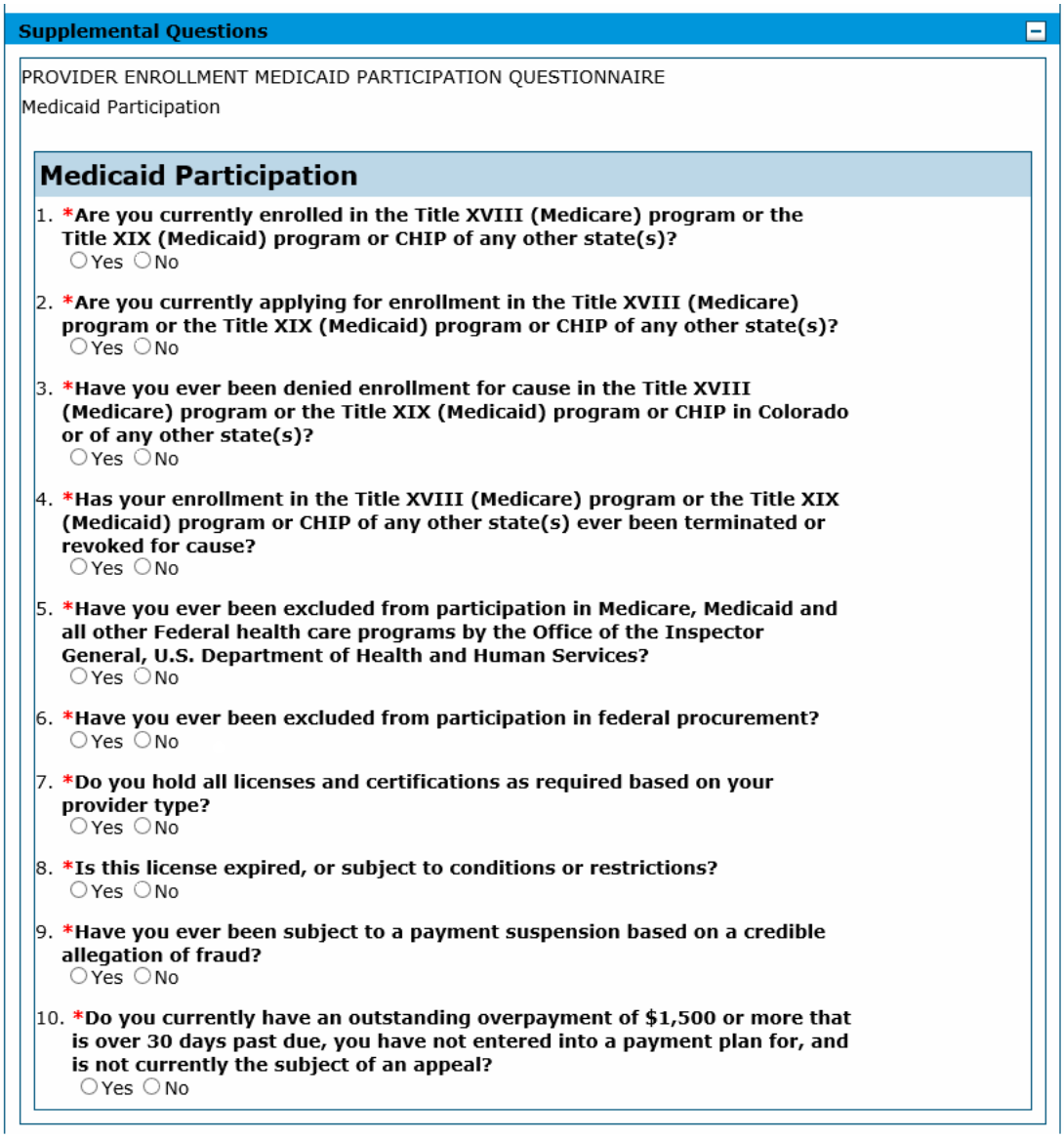


If a language needs to be removed, click the “Remove” link in the “Action” column.



Other Information Panel





Supplemental Questions

PROVIDER ENROLLMENT MEDICAID PARTICIPATION QUESTIONNAIRE

Medicaid Participation

Medicaid Participation

1. ***Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   ○ Yes ○ 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)?**
   ○ Yes ○ 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)?**
   ○ Yes ○ 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?**
   ○ Yes ○ 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?**
   ○ Yes ○ No
6. ***Have you ever been excluded from participation in federal procurement?**
   ○ Yes ○ No
7. ***Do you hold all licenses and certifications as required based on your provider type?**
   ○ Yes ○ No
8. ***Is this license expired, or subject to conditions or restrictions?**
   ○ Yes ○ No
9. ***Have you ever been subject to a payment suspension based on a credible allegation of fraud?**
   ○ Yes ○ 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?**
    ○ Yes ○ No

An individual enrollment with a provider type 24 Non-physician Practitioner Individual (Registered Nurses only) will have the following section displayed:

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
⊟	Click to collapse.			

Last Name **First Name**

NPI

Add Reset

Within this panel the provider will be able to:

- Review and update Malpractice/General Liability Insurance information.
- Review and update Certification records.
- Answer the Supplemental questions. Each question must have an answer before the provider is permitted to continue.
- Review and update Institutional Bed information. If updating bed information, the license is required to be attached showing the number of hospital beds.
- Review and update the website address.

Registered Nurses are required to complete and attach the RN Supervision form. This may be found on the Provider Forms web page on the Department website under the dropdown heading 'Provider Enrollment and Update Forms'.

When updating certification information, license information, or hospital bed information, attach a current copy of the applicable documentation to verify the information. Refer to the Attachments and Fees Panel section.
Note: Insurance information is required to be entered for all provider types. Only some provider types are required to include an insurance attachment. Please refer to the Provider Type Information for Revalidation web page to determine if your provider type is required to attach proof of insurance policy.

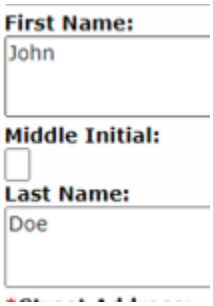
Disclosures Panel

Each of the disclosures are required to be completed with current information.

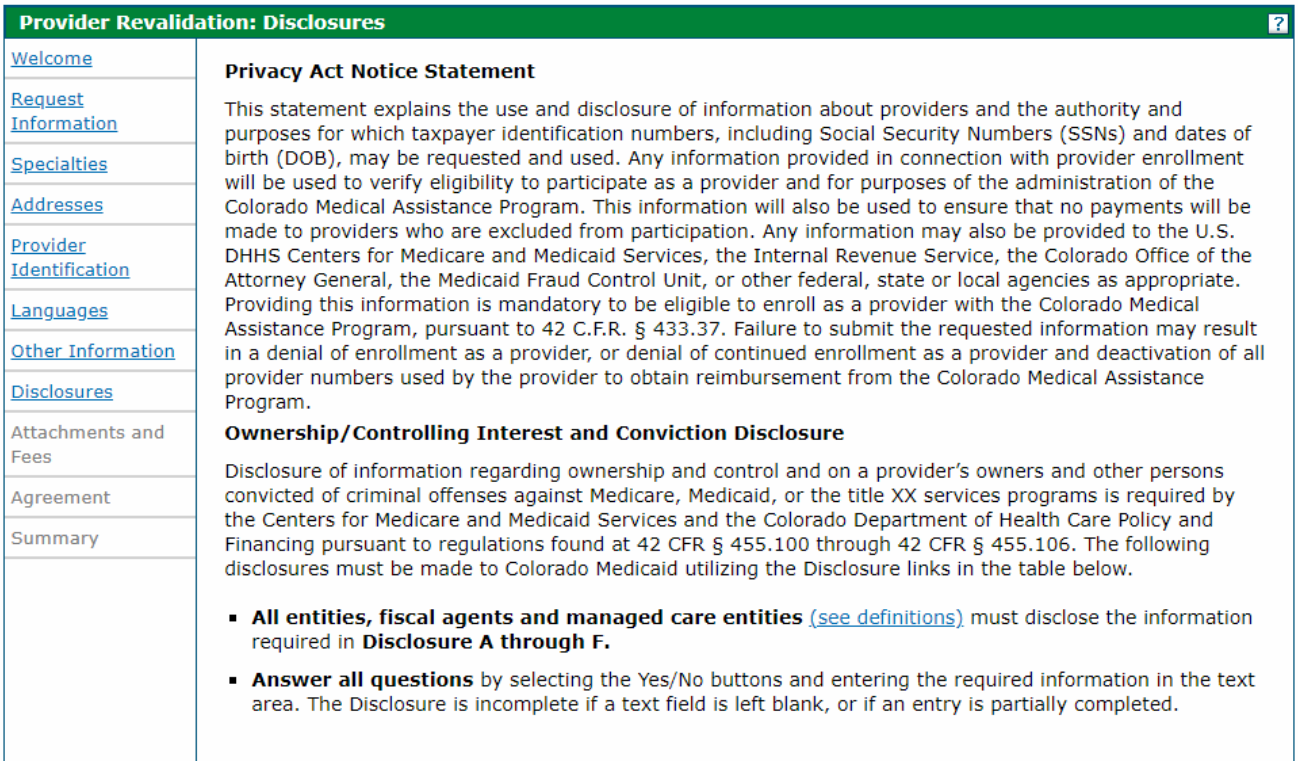
When entering information into any of the disclosures, it is important to take note of the following tips:

- There is a limit of 50 characters in all fields. The system will allow the user to enter more than 50 characters, however this may cause system issues during processing if more than 50 characters are entered.
- Enter organizational entities in the Organization Name field, all on one line with no extra spacing or information.
    - Example: ABC Company
    - Example of what not to enter:
        - A B C Company
        - ABC Company (2 spaces between ABC and Company)
        - Company, ABC
        - ABC Company but it used to be 123 Company before we changed…. (Please do not add any additional information in these fields. Only the name of the entity).
        - ABC
          Company

- 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 for John Doe:



    - Example of what not to enter:
        - John Smith (all in the same field)
        - Mr. John (Please do not include prefixes).
        - Smith, CEO (Please do not included a suffix).
        - John Smith but he just became owner because it used to be owned by…… (Please do not add any additional information in these fields. Only the name of the entity).



Available Revalidation Disclosures

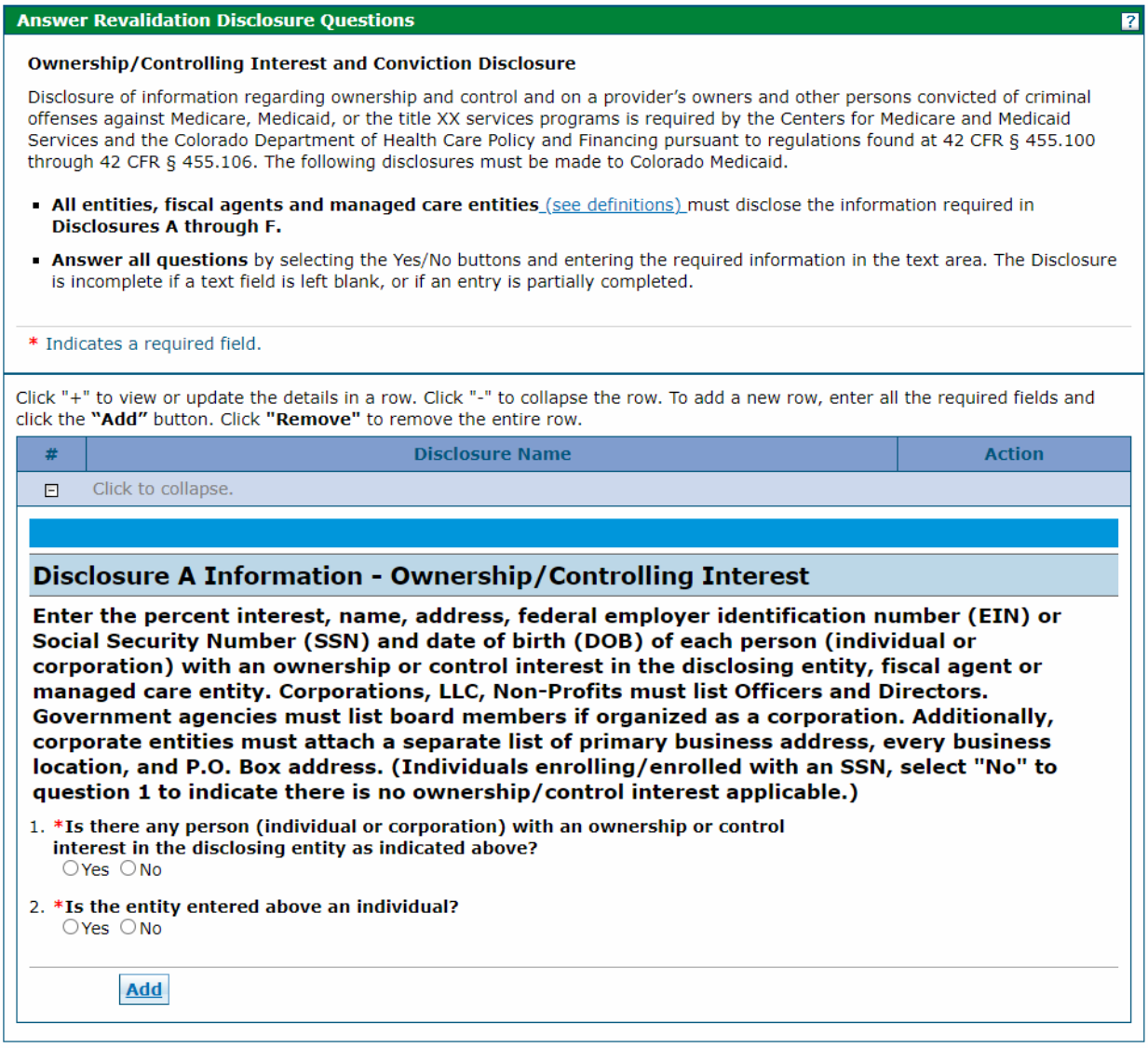
Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

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

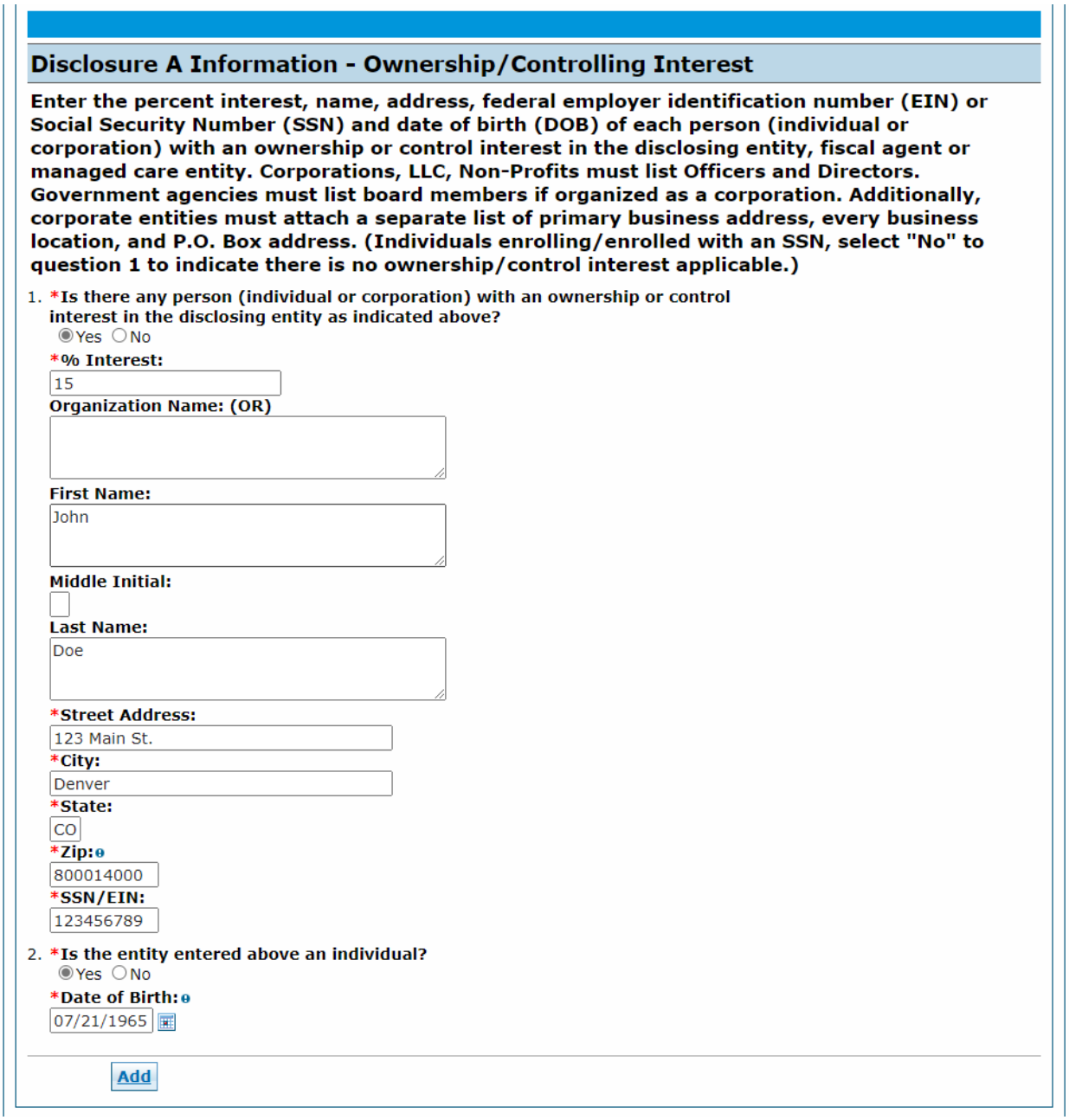
Continue Finish Later Cancel

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

Disclosures Panel – Ownership/Controlling Interest Disclosure A



A "Yes" answer will open an additional section as shown below, for the required information to be entered.



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.)

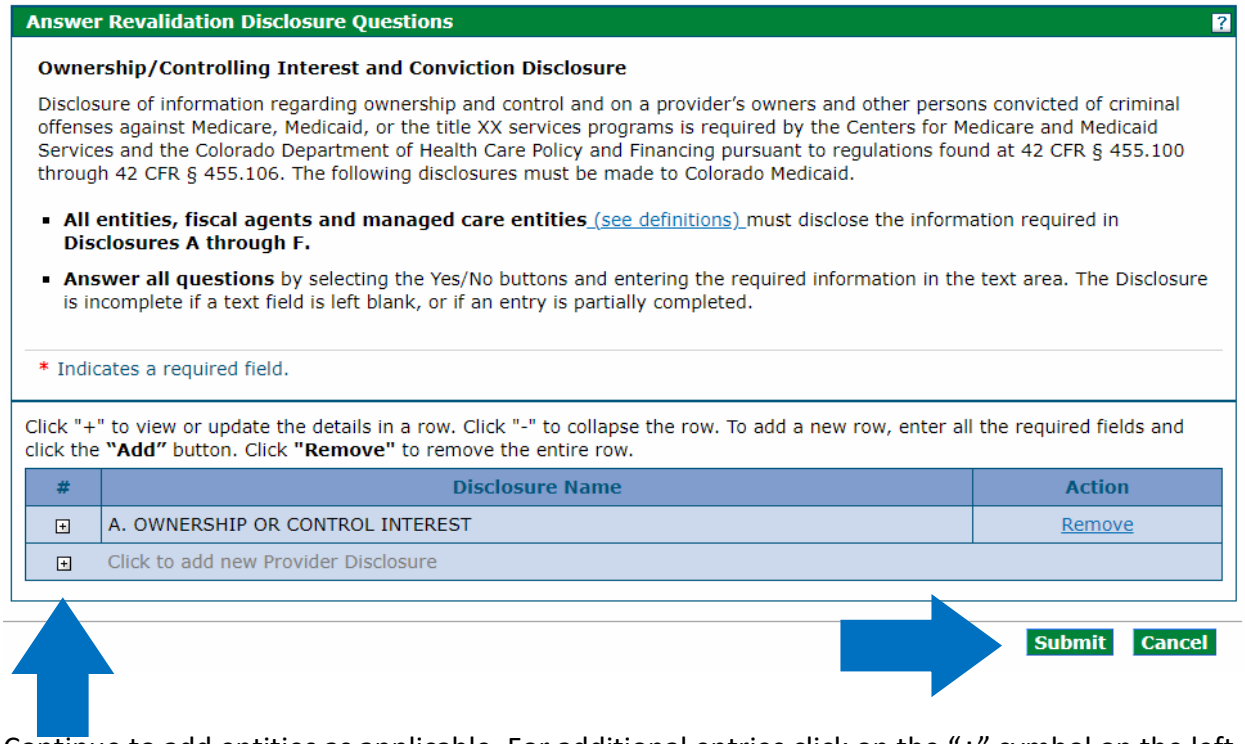
1. *Is there any person (individual or corporation) with an ownership or control interest in the disclosing entity as indicated above?
   (•) Yes ( ) No
   *% Interest: 15
   Organization Name: (OR)
   First Name: John
   Middle Initial:
   Last Name: Doe
   *Street Address: 123 Main St.
   *City: Denver
   *State: CO
   *Zip: 800014000
   *SSN/EIN: 123456789
2. *Is the entity entered above an individual?
   (•) Yes ( ) No
   *Date of Birth: 07/21/1965

Add

If the entity is an individual, then question 2 must be checked “Yes” to enter the individual’s “Date of Birth”, as shown above. If the user selects that the entity is not an individual, but enters information for an individual, the application will be returned to the user to correct the information.

When this information is complete, click the “Add” button and the panel will update as shown below.

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



Continue to add entities as applicable. For additional entries click on the "**+**" symbol on the left-hand side of the panel.

When all Ownership/Controlling Interest is entered, click on the "Submit" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed", as shown below.

Disclosures Panel – Ownership/Controlling Interest Disclosure A – Completed

Available Revalidation Disclosures

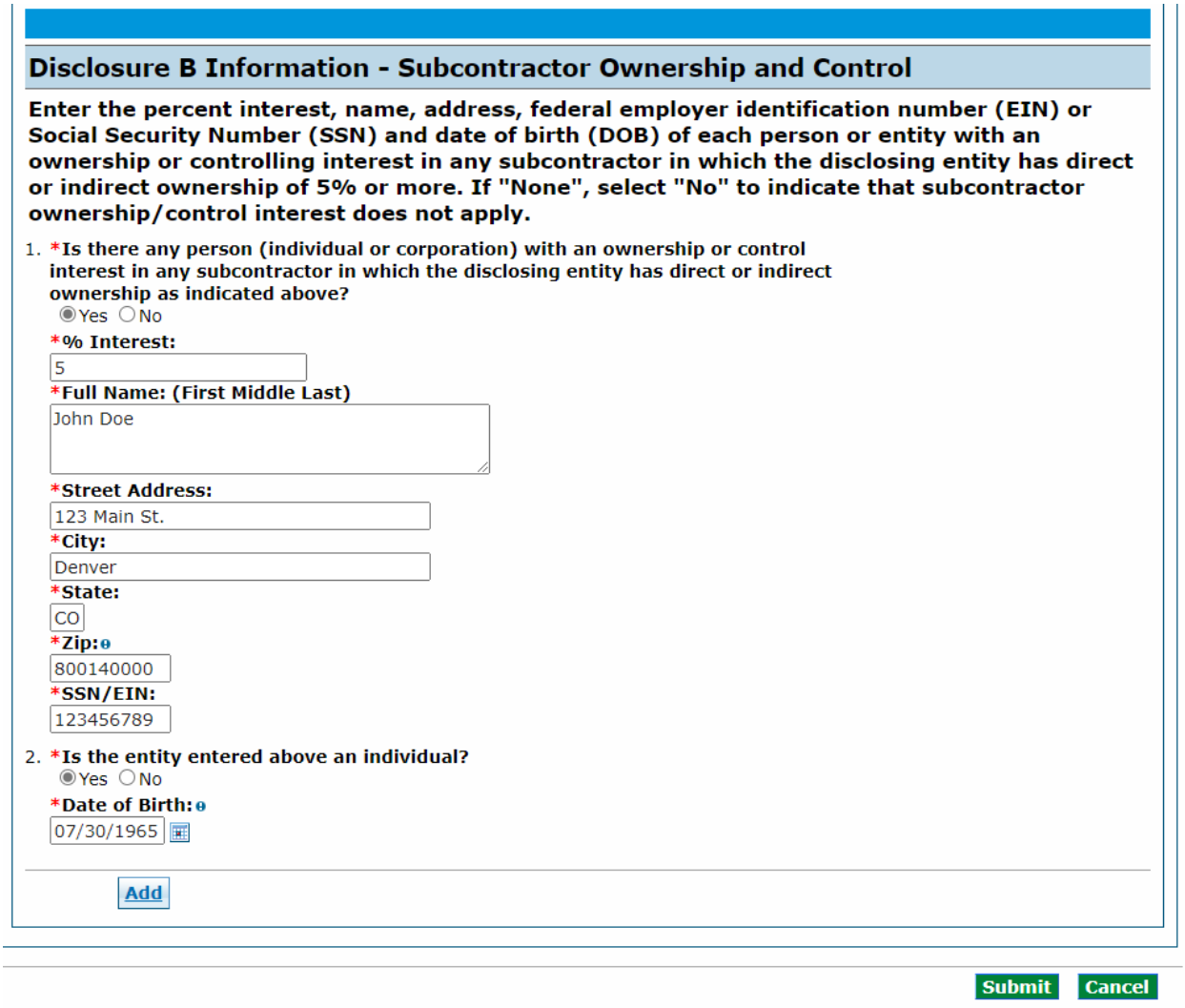
Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

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.

A "Yes" answer will open an additional section for the required information to be entered. When the information is completed, click the "Add" button and the panel will update.

Disclosures Panel – Subcontractor Ownership and Control Disclosure B - Questions

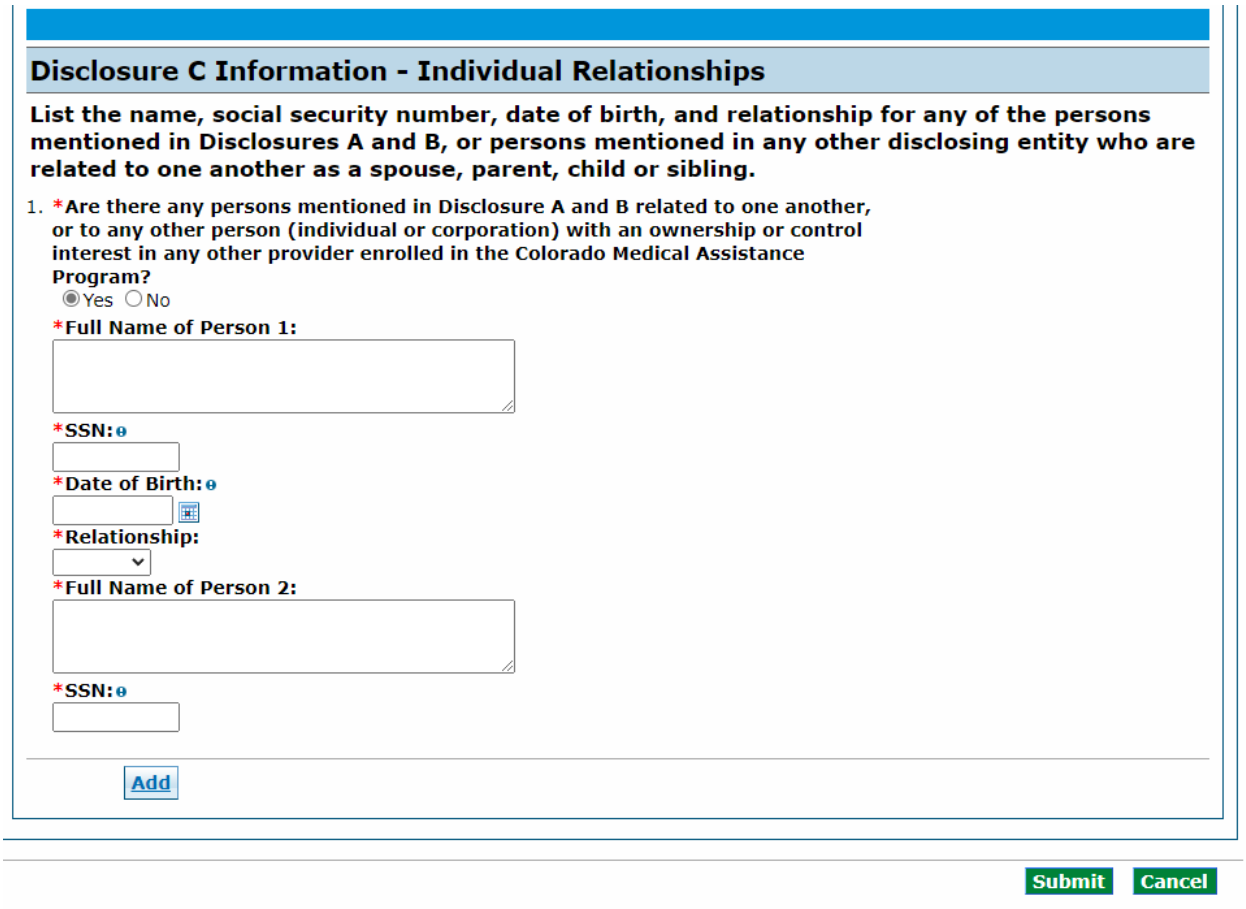


Continue to add entities as applicable. When all Subcontractor Ownership and Control information is entered, click on the "Submit" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed".

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.

A "Yes" answer will open an additional section for the required information to be entered.

Disclosures Panel – Individual Relationships Disclosure C – Questions



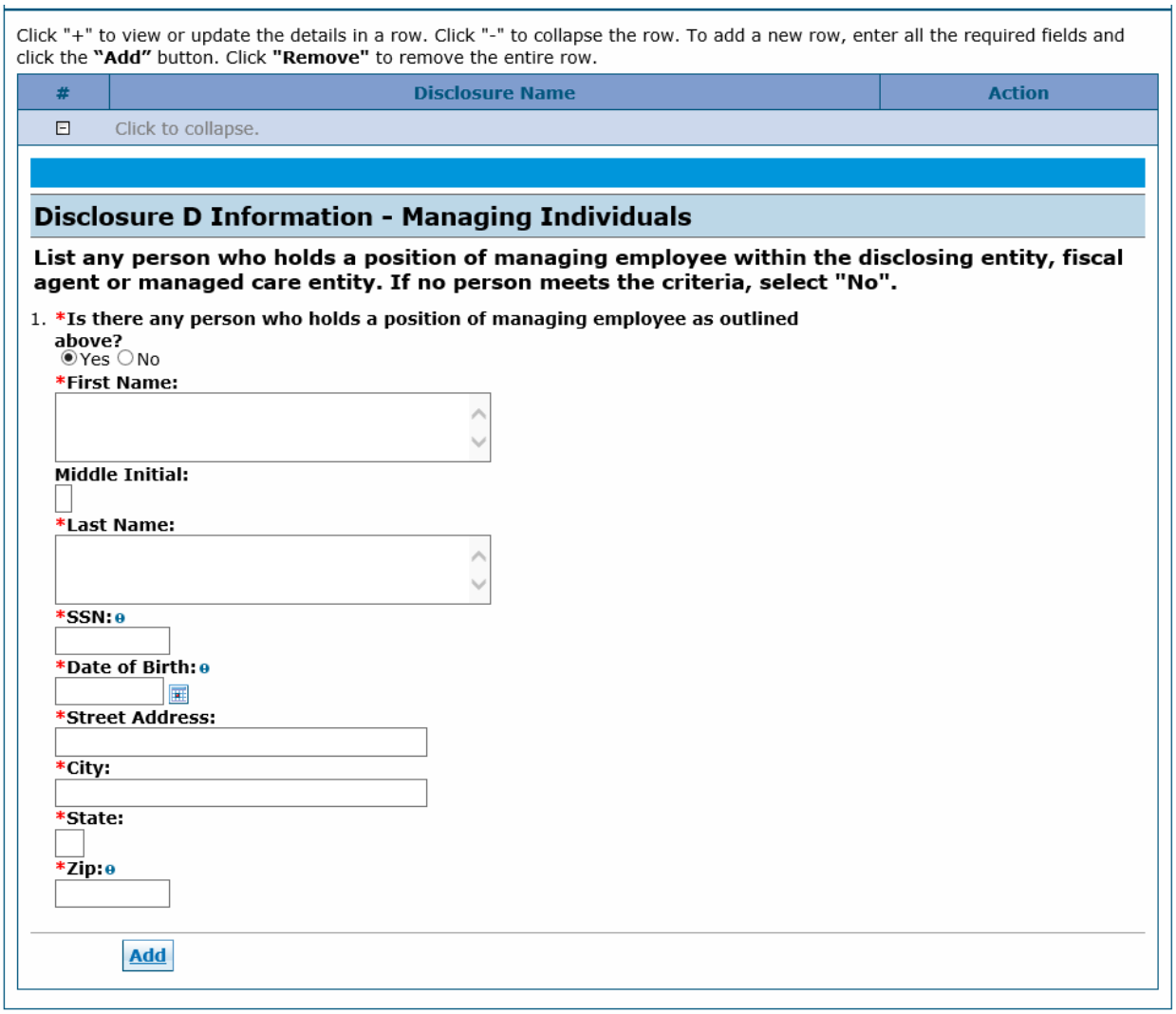
When the information is completed, click the "Add" button and the panel will update.

Continue to add individuals as applicable. When all Individual Relationships are entered, click on the "Submit" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed".

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

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “Add” button and the panel will update.

Disclosures Panel – Managing Individuals Disclosure D – Questions

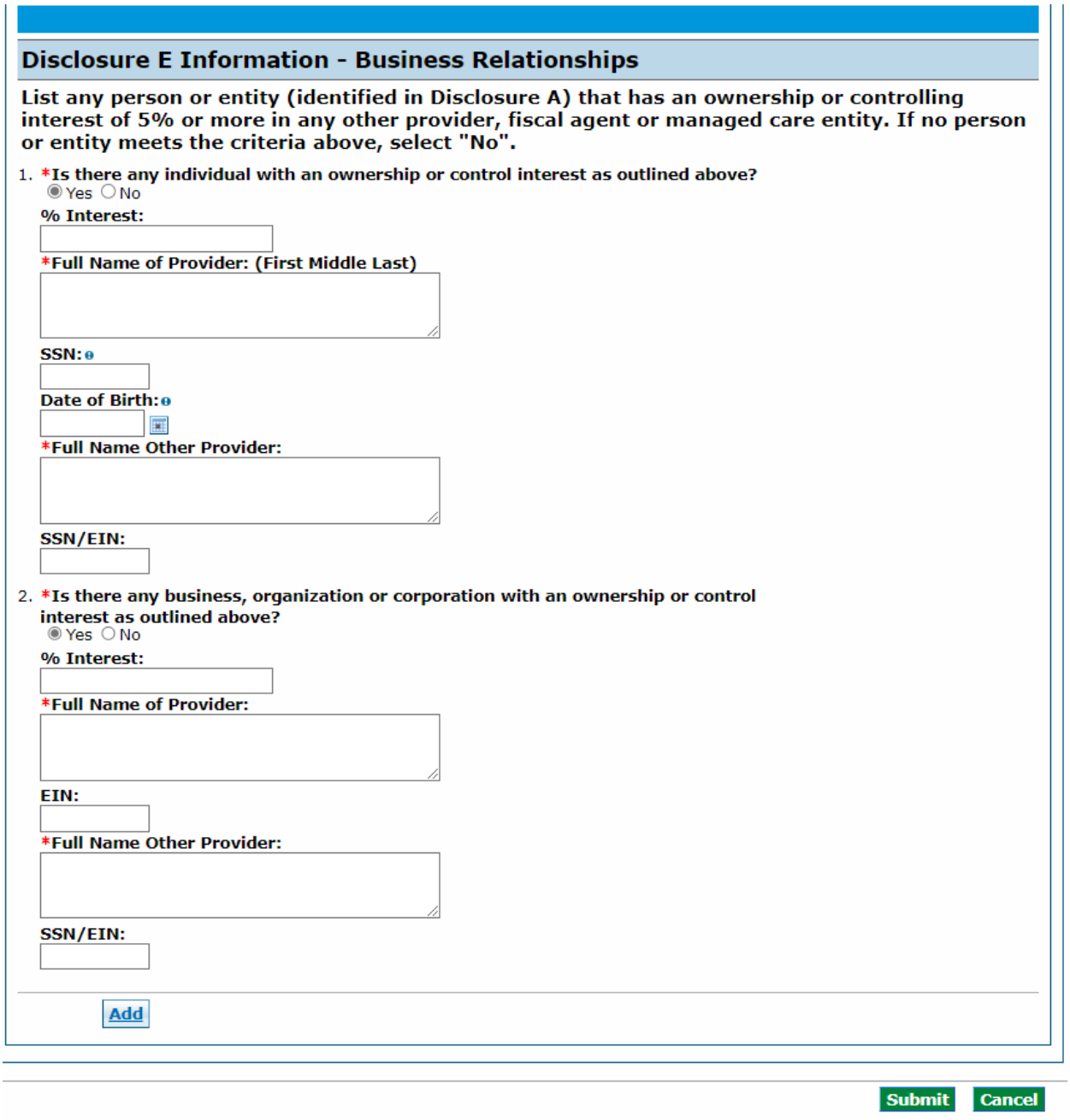


Continue to add individuals as applicable. When all Managing Individuals are entered, click on the “Submit” button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect “Completed”.

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.

A “Yes” answer will open an additional section for the required information to be entered. When the information is completed, click the “Add” button and the panel will update.

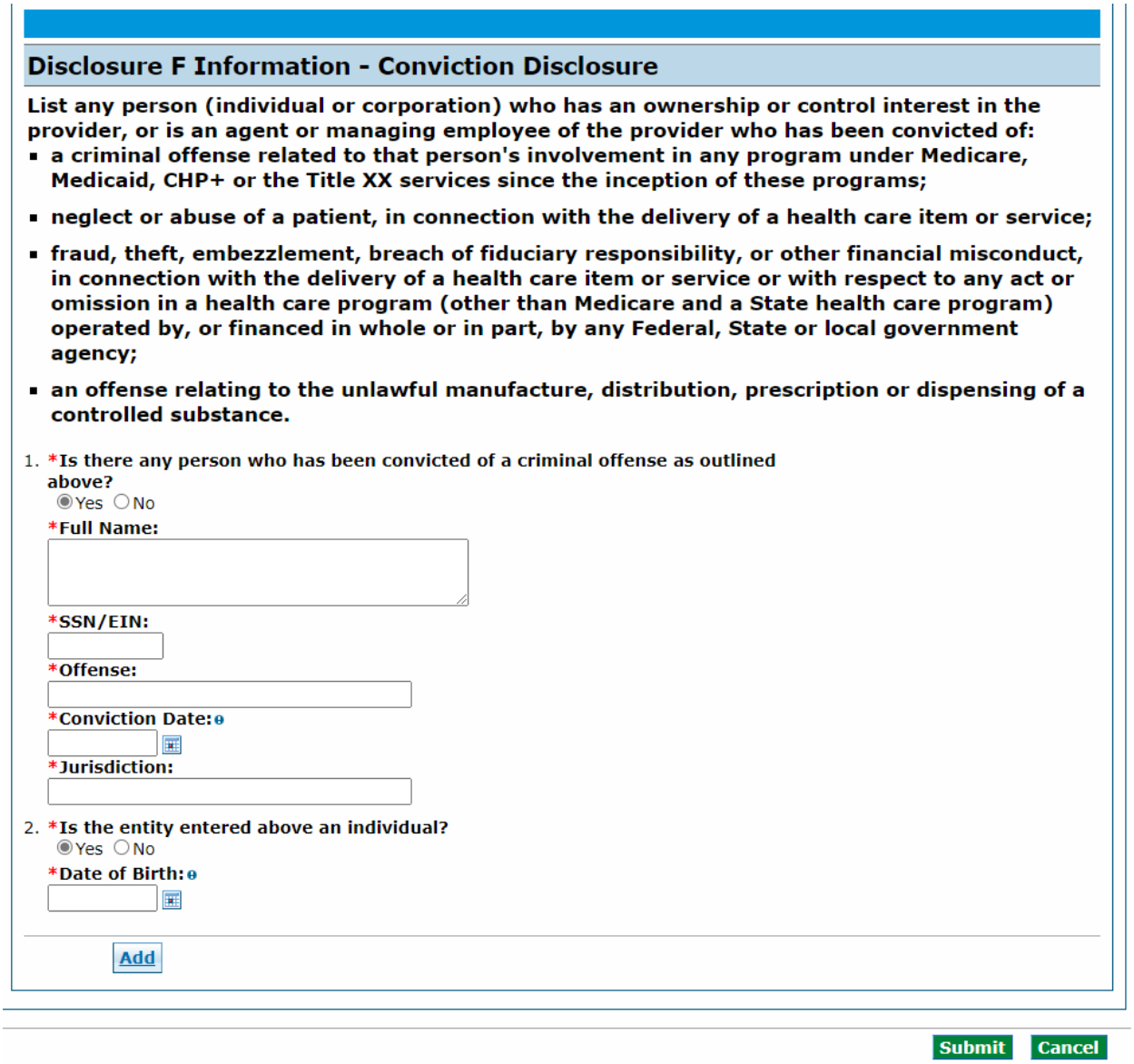
Disclosures Panel – Business Relationships Disclosure E– Questions



Continue to add entities as applicable. When all Business Relationships are entered, click on the "Submit" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "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



A "Yes" answer will open an additional section for the required information to be entered. When the information is completed, click the "Add" button and the panel will update.

Continue to add entities as applicable. When all Convictions are entered, click on the "Submit" button on the right-hand side of the panel. The panel will update and this item on the Disclosure list will now reflect "Completed".

When all questions have been completed within the Disclosures panel, select “Continue”, “Finish Later” or “Cancel”.

Disclosures Panel – Completed

Available Revalidation Disclosures

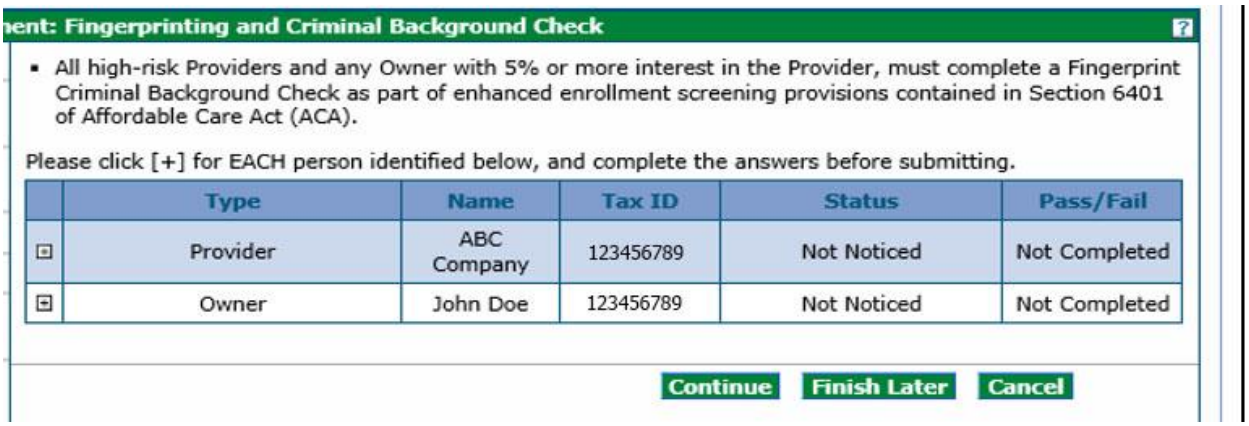
Click the disclosure name to open the disclosure for editing. After completing the disclosure, select **"Add"**. When you have completed the disclosure, click **"Submit"** to return to the main Disclosures page. All Disclosures must be completed to **Continue**.

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

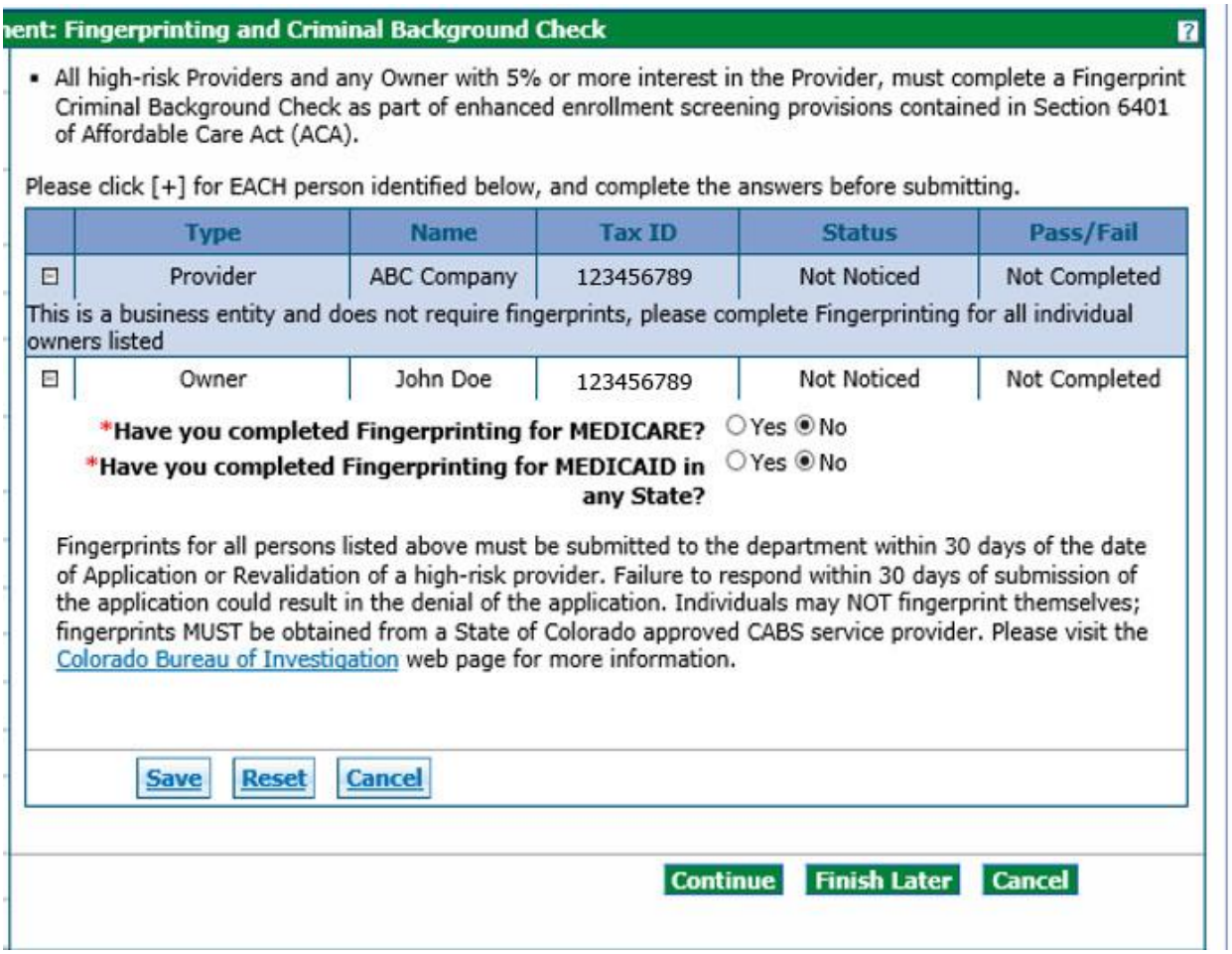
Continue Finish Later Cancel

Fingerprinting Panel

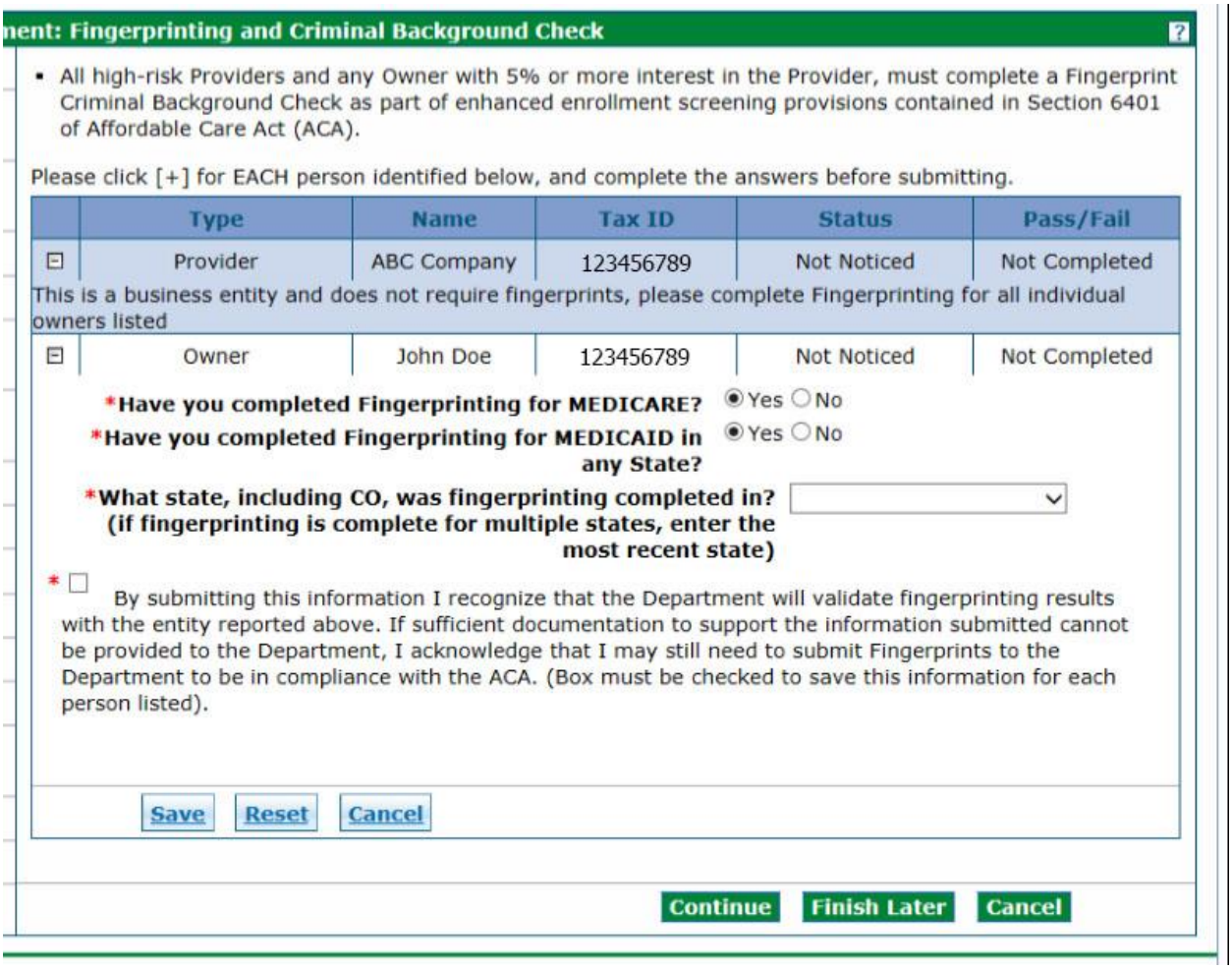
If the provider's Revalidation Risk Level is 'High’, the below panel will be displayed, and fingerprints are required for each individual owner that is listed with an ownership of 5% or more. Owner information is populated by the information that is entered in the Disclosures in the application. For providers that are business entities, all owners with 5% or more interest in the business will be displayed with a status indicating any individuals that need to submit fingerprints at this time.



If an Owner has **not** completed their Fingerprinting and Criminal Background Check (for either **MEDICARE or MEDICAID**), please follow the instructions on this panel to have fingerprints submitted within 30 calendar days of the submission of the Revalidation application. Please review the Fingerprinting FAQ on the Provider FAQ Central web page and select the Fingerprinting drop-down section.



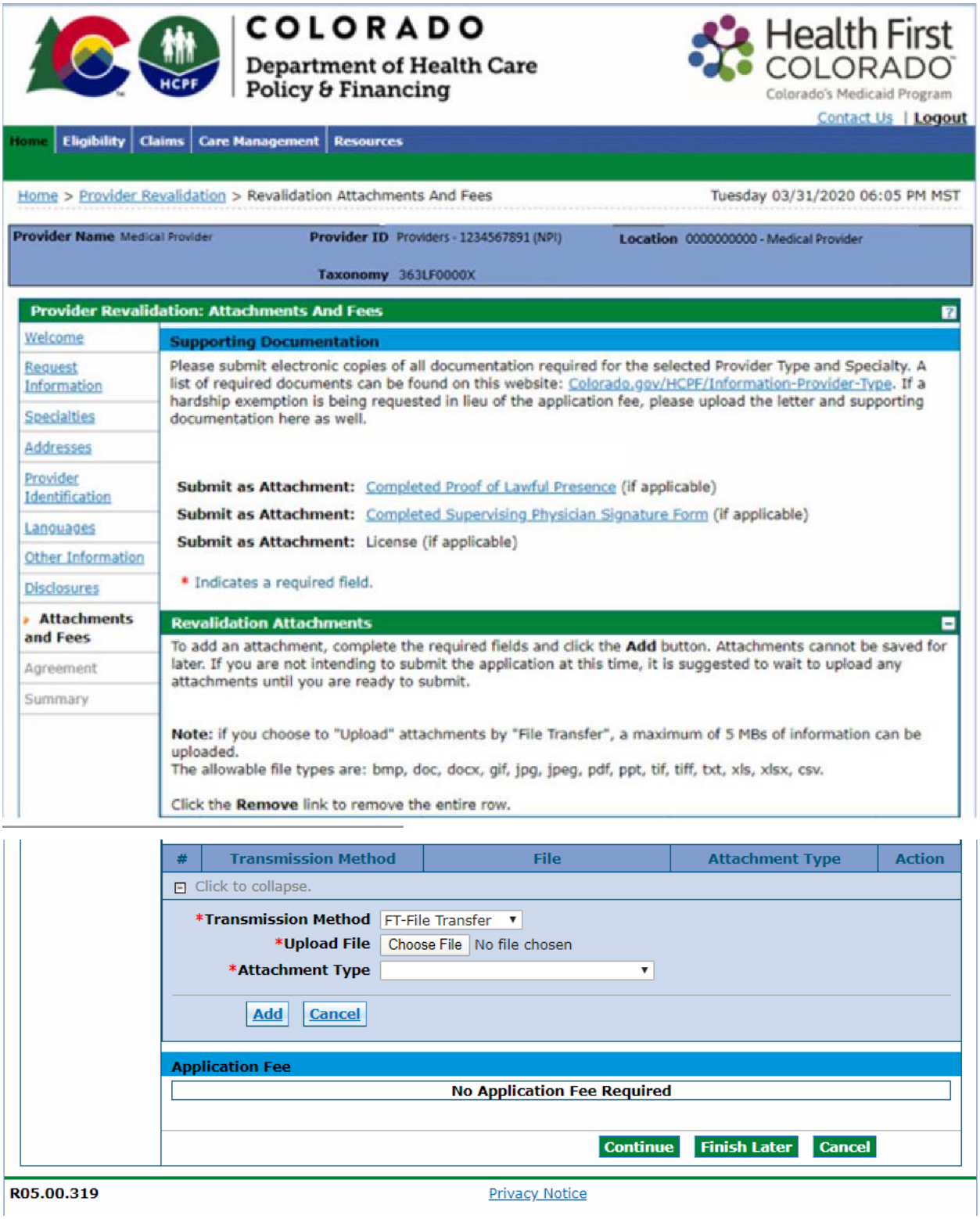
If an Owner has completed their Fingerprinting and Criminal Background Check (for either **MEDICARE or MEDICAID**), mark "Yes" next to the appropriate selection. If marked "Yes", the panel will update and request confirmation of which state the fingerprinting was completed in. Then check the box next to the acknowledgement statement.



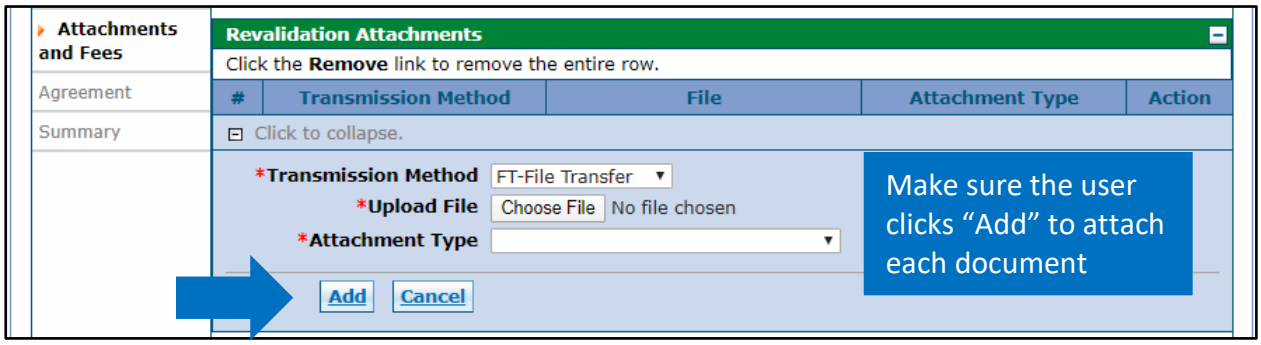
Click "Save" once completed for **each Owner** and then click "Continue" to the next section.

Once the application is submitted, Providers and owners requiring fingerprinting will be given specific instructions on how to proceed.

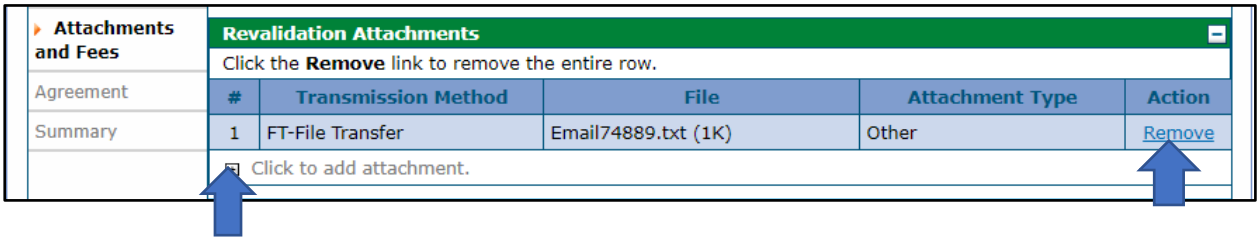
Attachments and Fees Panel



Attachments Section



Select the ‘+’ sign to add each attachment as needed. Select the ‘Remove’ link to remove an attachment. Select ‘Continue’, ‘Finish Later’, or ‘Cancel’ once all attachments have been added.



Required attachments may be submitted electronically on this panel. Please note that attachments sent by mail, email or fax cannot be accepted. These must be added to the attachments and fees page of the Revalidation application.

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

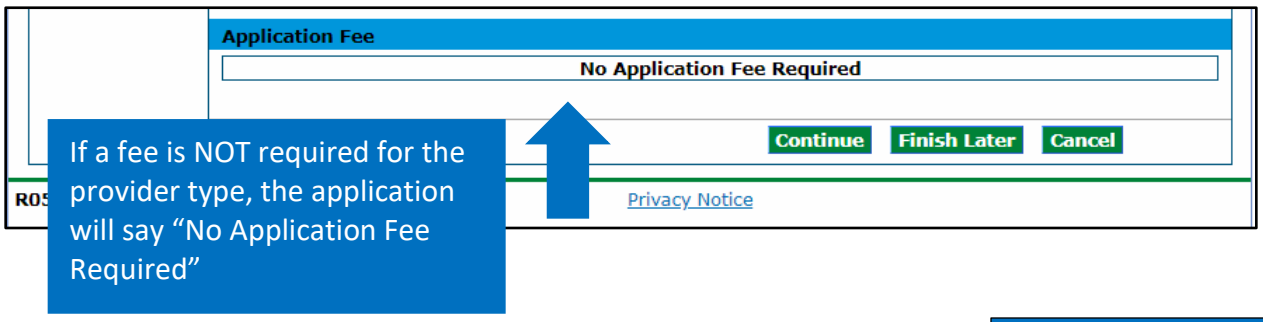
If any of the following information was added or updated in the Revalidation application, then a current copy is required to be included:

- Licenses
- Certifications
- Malpractice/General Liability insurance (nursing facilities only)
- Institutional bed information – License required

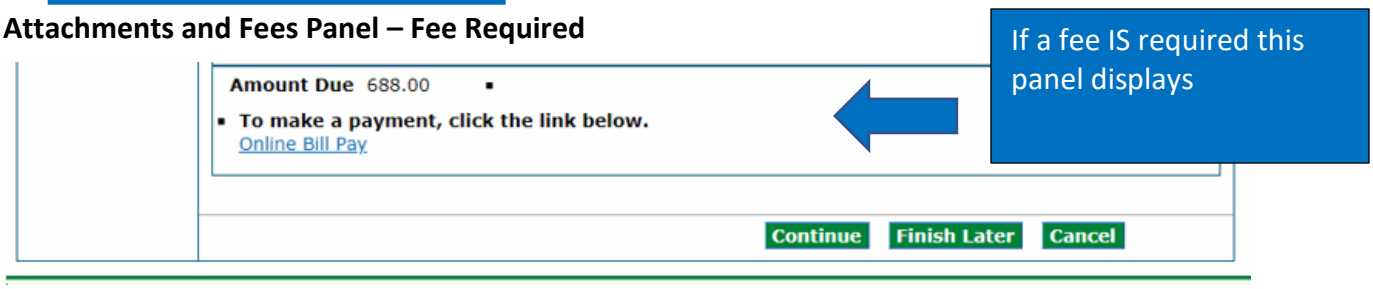
Application Fee Section

The application fee is required to be paid during revalidation. The Application Fee questions as shown in the panel below will only be displayed when applicable. If the service location has enrolled or revalidated with Medicare or another state’s Medicaid program in the last 5 years, and paid an application fee, the application fee may not be required for revalidation. A copy of the receipt indicating payment must be uploaded on this page in the attachments section with a selection type of “Other”.

Attachments and Fees Panel – No Fee Required

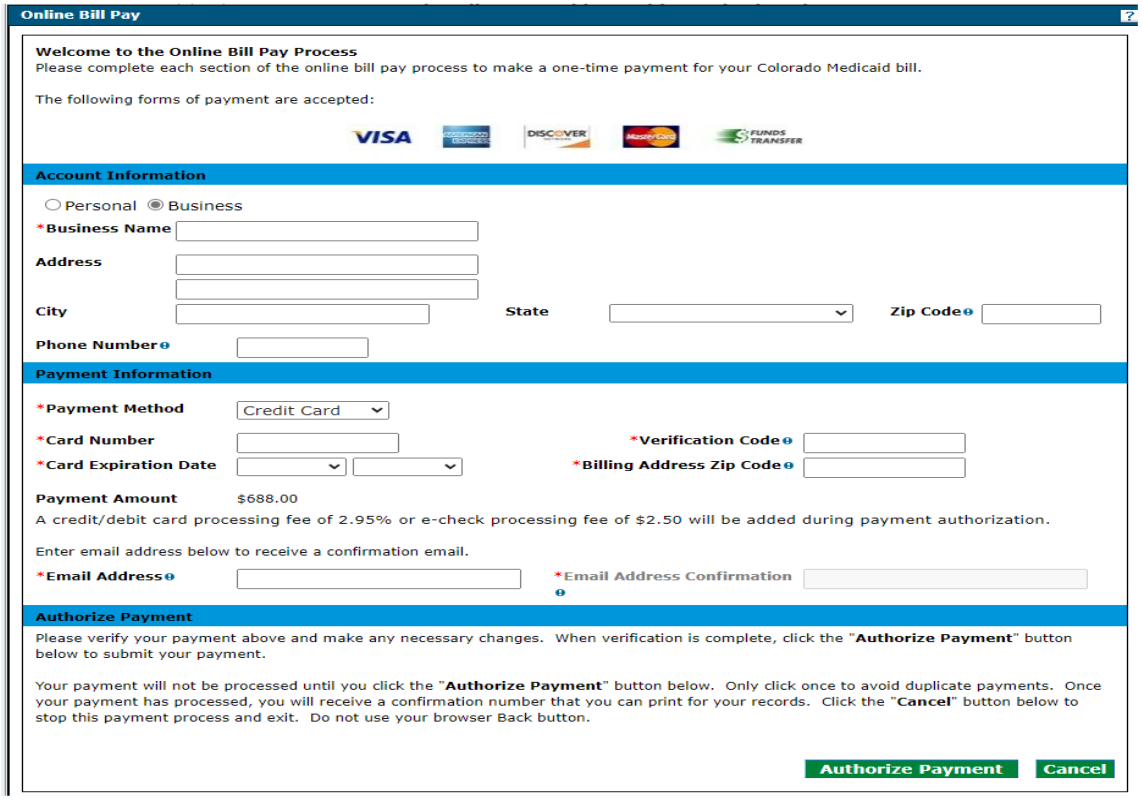


Attachments and Fees Panel – Fee Required

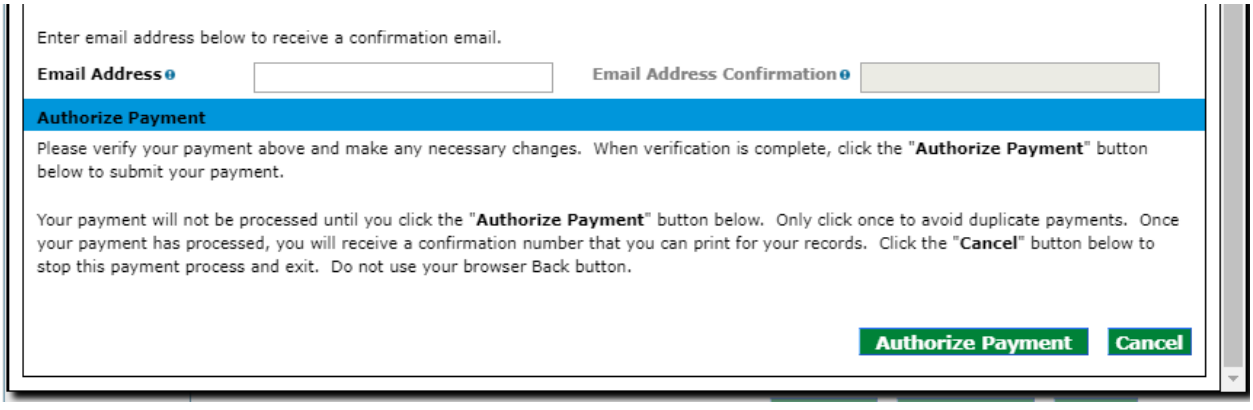


Financial Hardship – If the user is requesting a waiver for financial hardship, include a letter describing the financial hardship and why the hardship justifies an exception, as well as any additional supporting documentation that the user believes may aid the Department and CMS (Centers for Medicare & Medicaid Services) in the determination. The 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, tax returns, etc. If the user chooses to apply for an application fee waiver, the revalidation will be delayed while a determination is made. The letter and supporting documentation must be uploaded on this page in the attachments section with a selection type of "Other".

If it is determined that an application fee is due, click the "Online Bill Pay" link, and a payment form will open in a pop-up window:

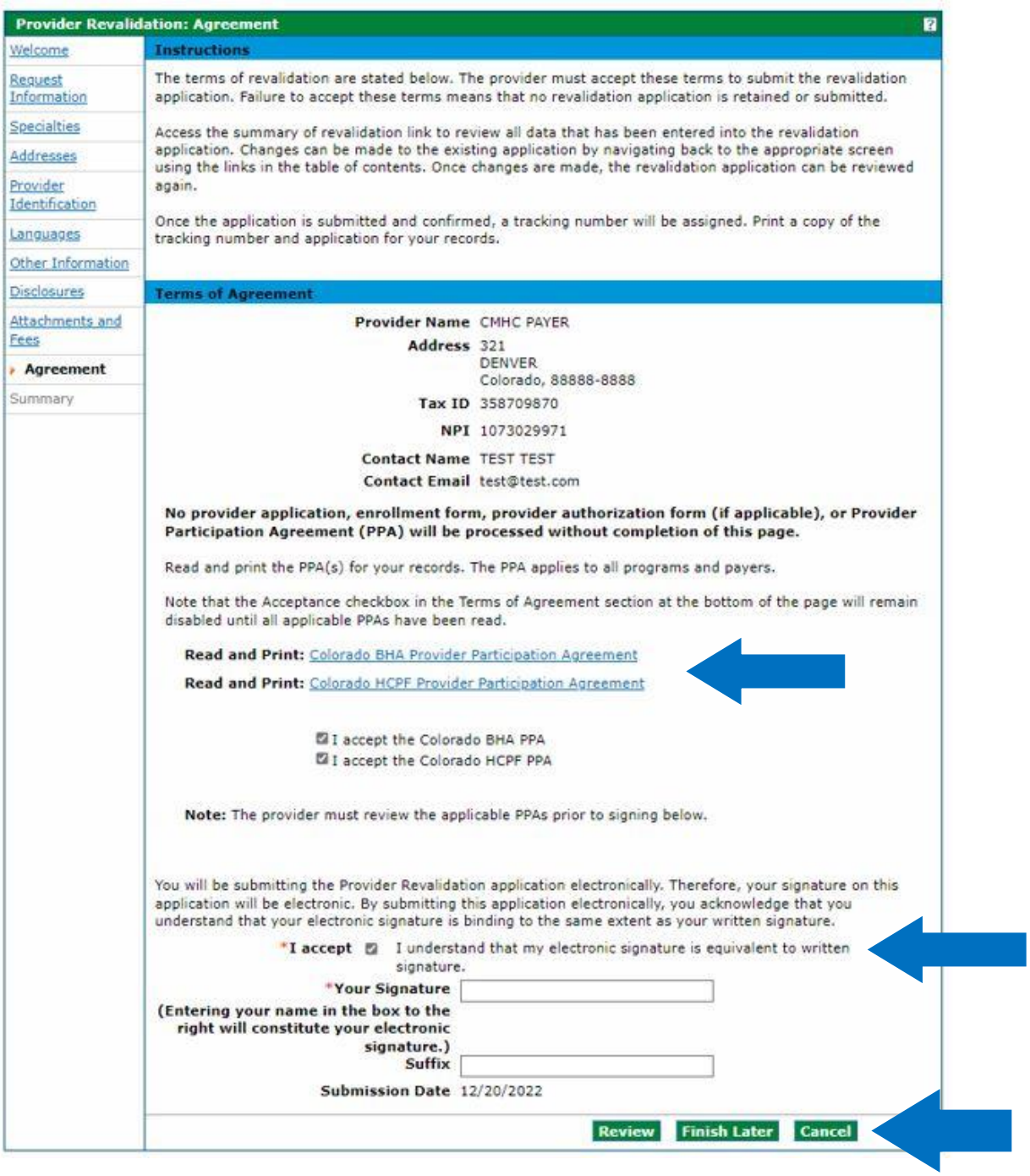


Note: A processing fee of 2.95% is charged for a debit/credit card payment, and a processing fee of $2.50 is charged for an e-check.



Agreement Panel

All provider participation agreements must be read and accepted before submitting the revalidation application.

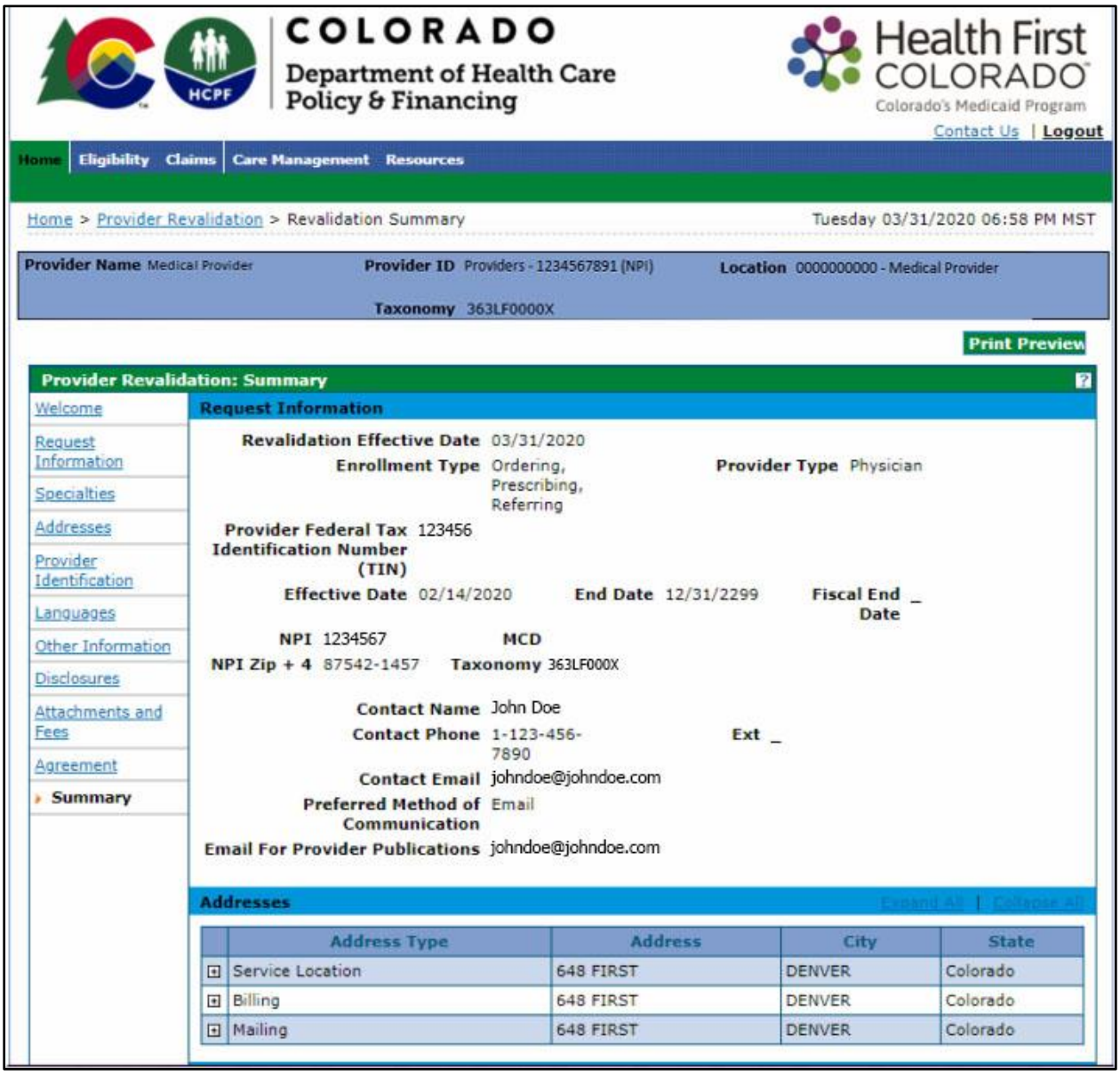


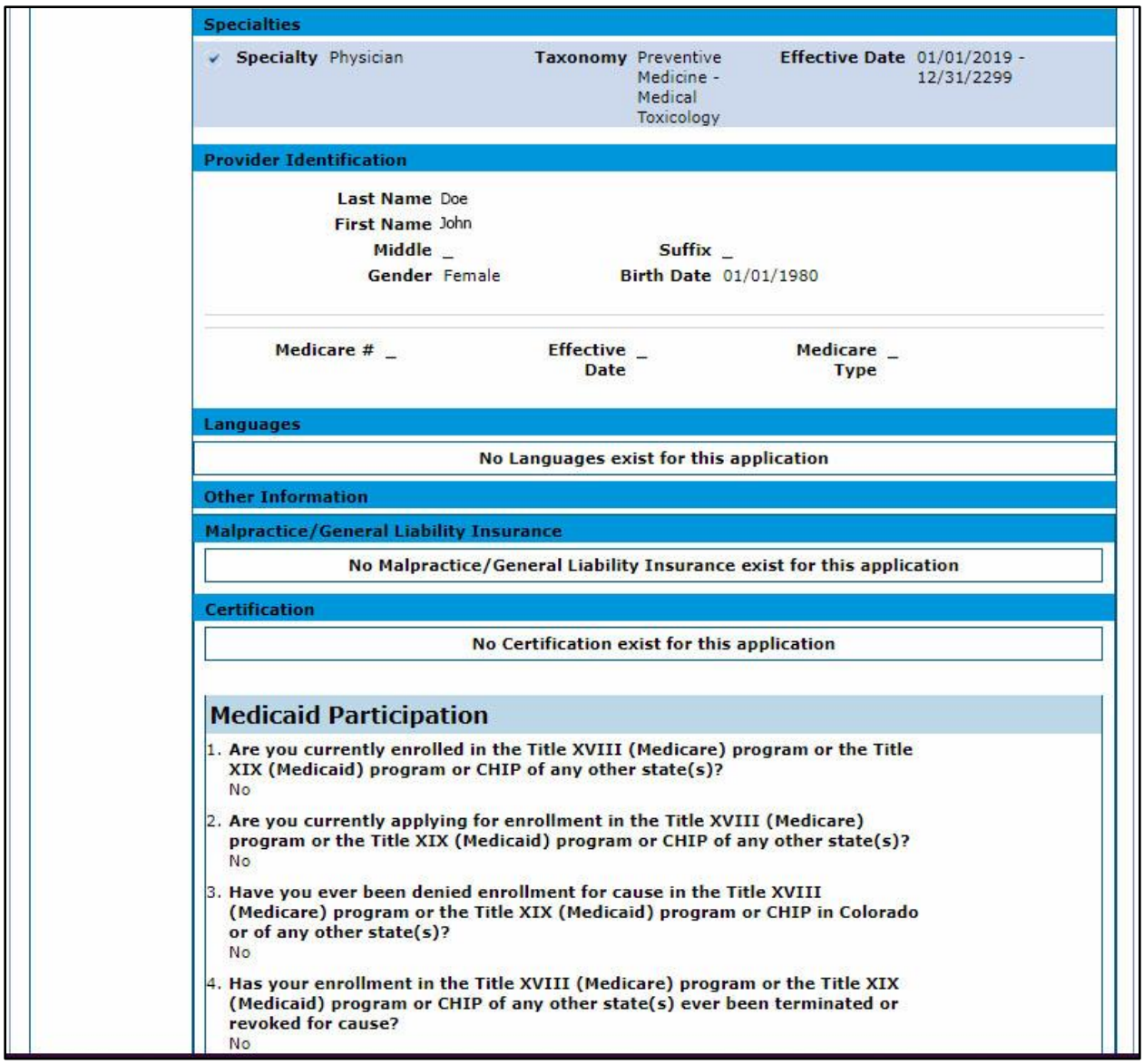
Once complete, a checkmark will appear.

Enter the Provider name as the electronic signature and click in the “I accept” box in order to complete the page. The “Review” button will then become active.

Summary Panel

This panel will show the Revalidation application in its entirety. At this point the user should review all information that has been entered for accuracy.





Specialties

✔ **Specialty** Physician **Taxonomy** Preventive Medicine - Medical Toxicology **Effective Date** 01/01/2019 - 12/31/2299

Provider Identification

Last Name Doe
First Name John
Middle _ **Suffix** _
Gender Female **Birth Date** 01/01/1980

Medicare # _ **Effective Date** _ **Medicare Type** _

Languages

No Languages exist for this application

Other Information

Malpractice/General Liability Insurance

No Malpractice/General Liability Insurance exist for this application

Certification

No Certification exist for this application

Medicaid Participation

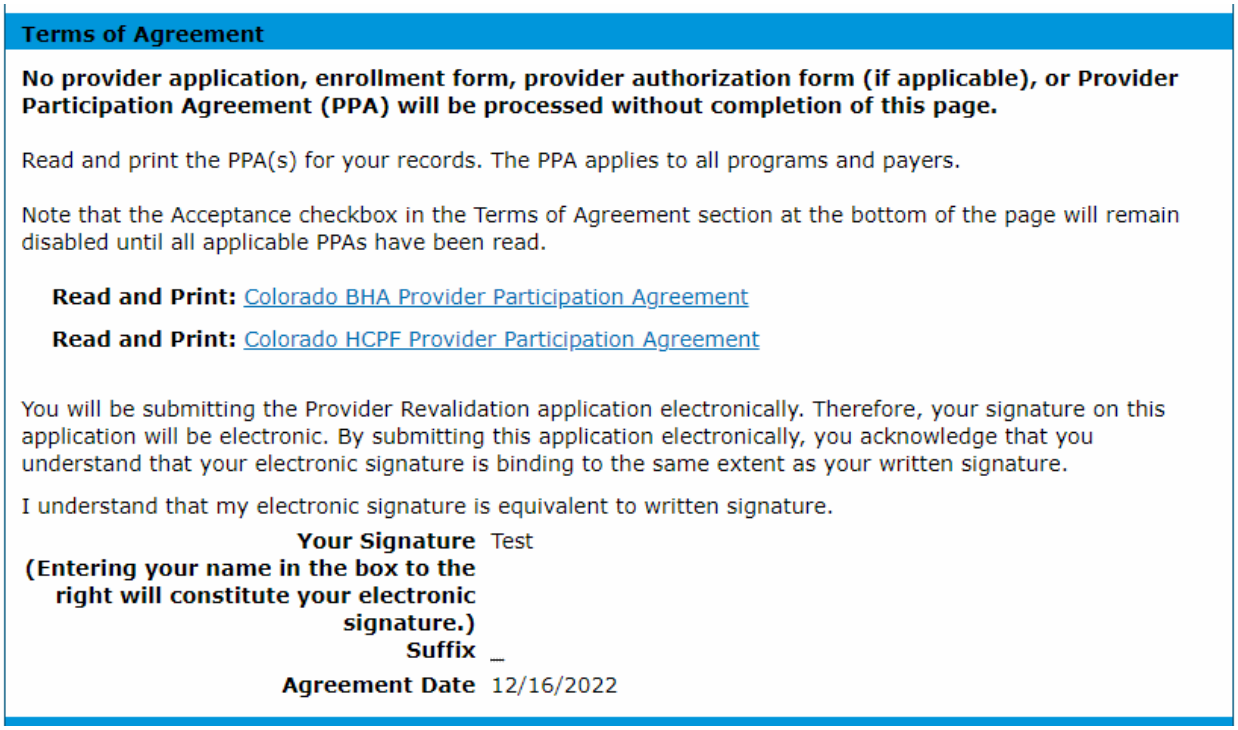
1. **Are you currently enrolled in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   No
2. **Are you currently applying for enrollment in the Title XVIII (Medicare) program or the Title XIX (Medicaid) program or CHIP of any other state(s)?**
   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?**
   No
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

Website Address _

Disclosures

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



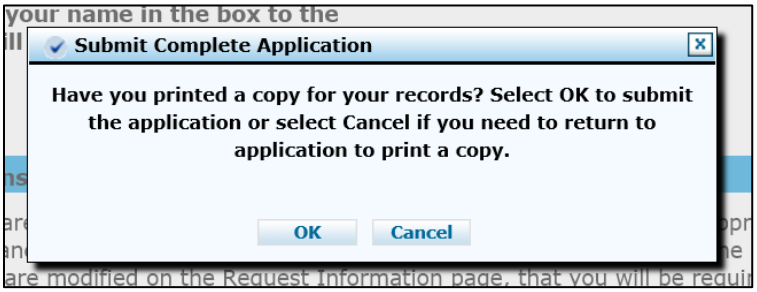
Print Preview – Select this button to print a copy of the Revalidation application. This will be the only opportunity to print a copy of the Revalidation application.

Submit – Select this button to submit the Revalidation application for review.

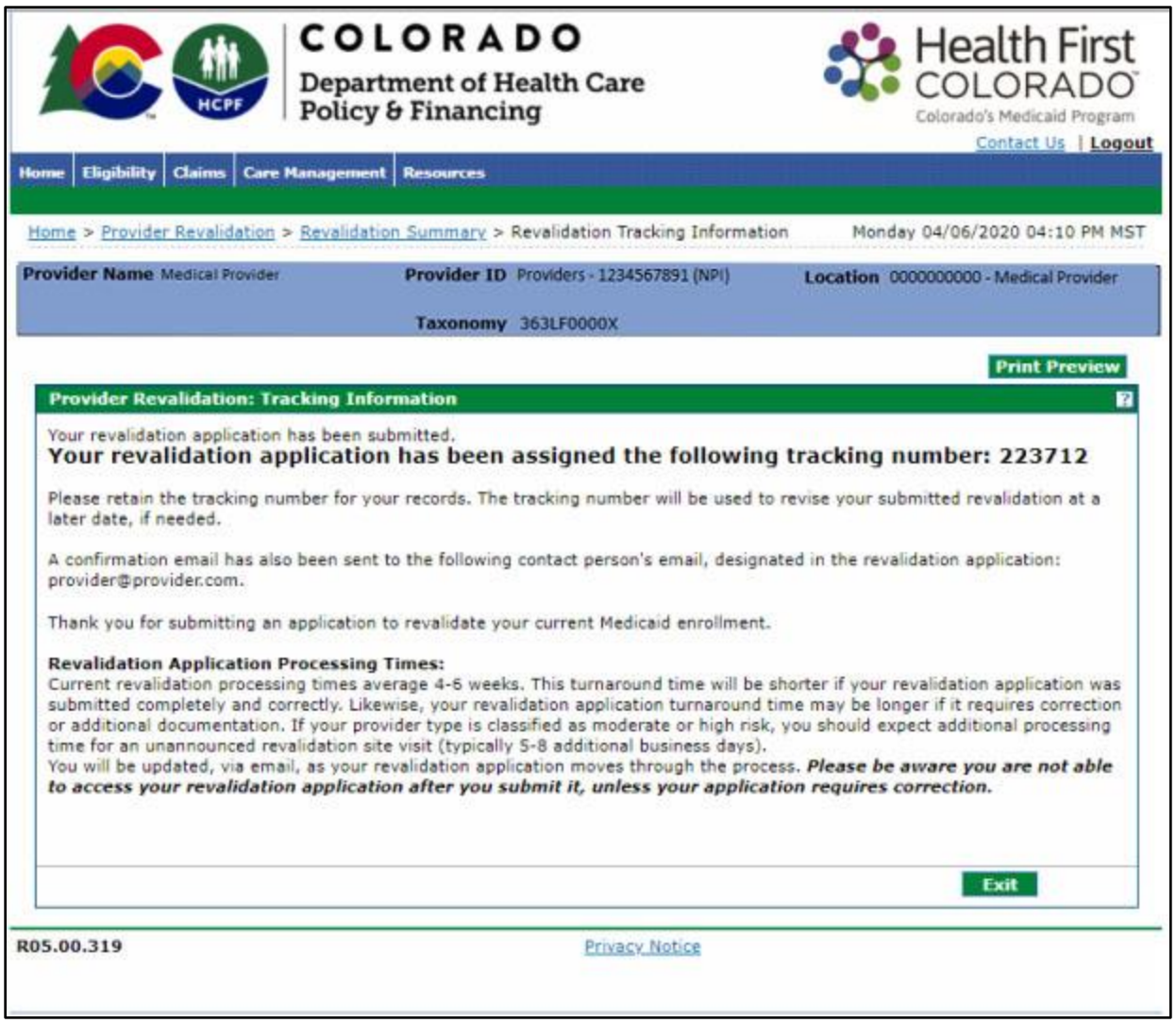
Finish Later – Select this button to save the information and finish the application later.

Cancel – Select this button to log out of the application without saving the information.

When the "Submit" button is selected, the user will be asked if they have printed a copy of this application for their records. If the user has already printed a copy, or does not wish to print a copy, click "OK". If the user would like to print a copy and has not done so yet, click "Cancel" to return to the application to print a copy.



Once the **"OK"** button has been selected, the provider will view the tracking number to the Revalidation application:



Select the "Exit" button to return to the **Welcome** panel.

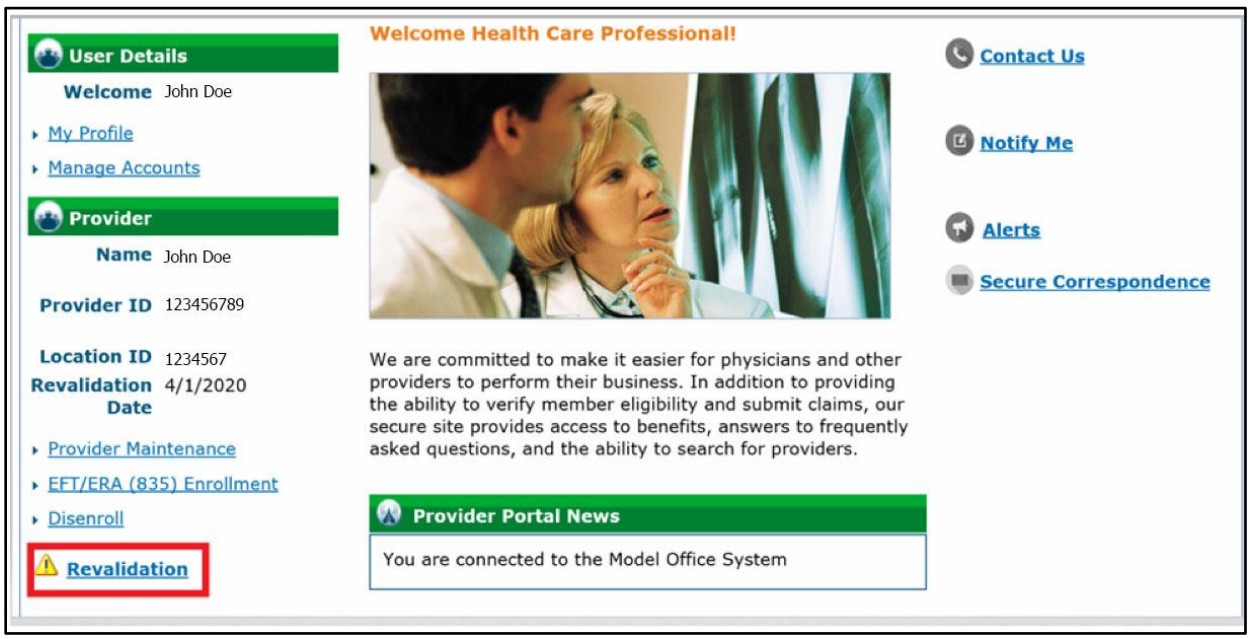
For additional support, providers may contact the Department's fiscal agent for Health First Colorado by calling the Provider Services Call Center at 1-844-235-2387.

Providers may also visit the For Our Providers web page for additional resources.

Resume Revalidation

If the user was unable to complete the revalidation process and elected to save the work, the process can be resumed by logging in to the Provider Web Portal and selecting the Revalidation link. The provider will be brought to the Revalidation application.

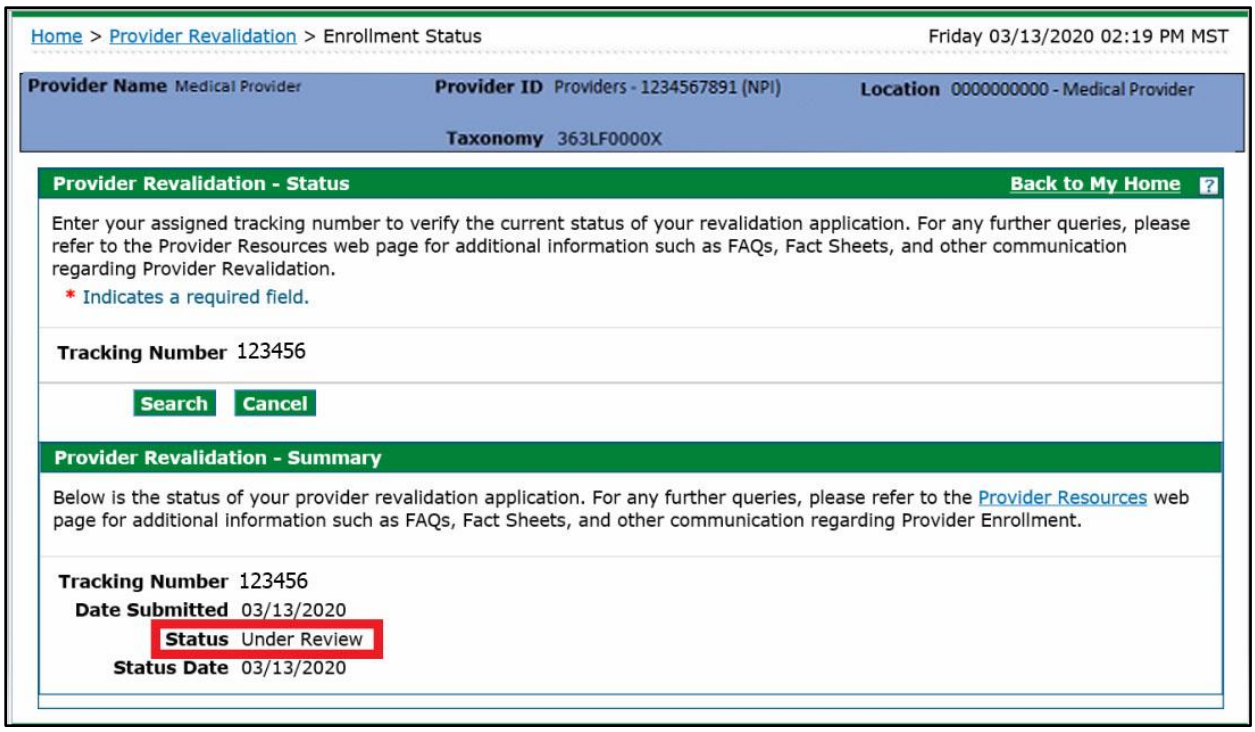
If the application was completed, but the user received a Return to Provider (RTP) email from fiscal agent stating additional or corrected information is needed, access the application using the same link.



Unless the Revalidation application is returned to a provider (RTP) for updates or corrections, no changes may be made to the information entered once the application is submitted.

Revalidation Status

If the application has been submitted for review, selecting the “Revalidation” link will bring the provider to the Provider Revalidation Status panel:

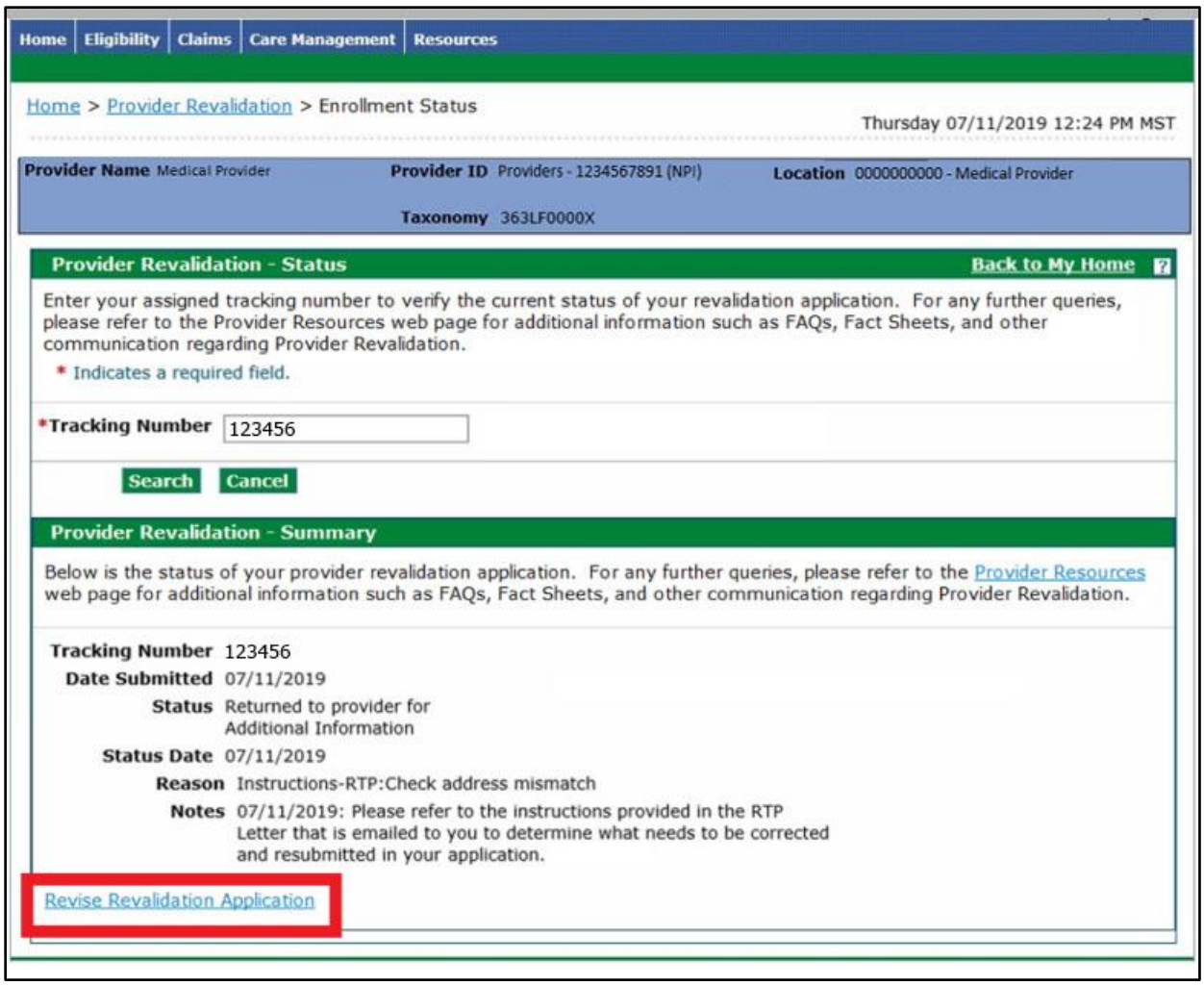


Even if there are notes here indicating the application needs to be returned to the provider, the user **WILL NOT** be able to access the application to make corrections until this status reads "Returned to Provider for Additional Information", "Returned to Provider for Additional Authorization(s)" or "Returned to Provider for Missing Documentation".

Once the Revalidation application is returned to the provider, a notification email is sent to the contact email address entered.

To make the required corrections the user will need to log in to the Provider Web Portal and select the revalidation link on the Welcome page. If the status indicates that corrections are needed, select the "Revise Revalidation Application" link as shown below.

This link only displays when the application is returned for corrections.



The user will then be brought to the Revalidation application to make the necessary corrections indicated in the letter and resubmit the Revalidation application.

Site Visits

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

The purpose is to verify that the information submitted to the Department of Health Care Policy & Financing (the Department) is accurate and to determine compliance with federal and state enrollment requirements. If the provider type falls into one of these risk categories, the user will be contacted for the required site visit. A representative will conduct a site visit for the service location to verify certain aspects of the revalidation. Providers that refuse a site visit may be excluded from participation.

For further information about risk categories by provider type, please refer to the risk levels on the Information by Provider Type Information for Revalidation web page

Provider Revalidation Notifications

The provider will receive several email notifications during the revalidation process which will be 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 reach out directly with questions about the Revalidation application.

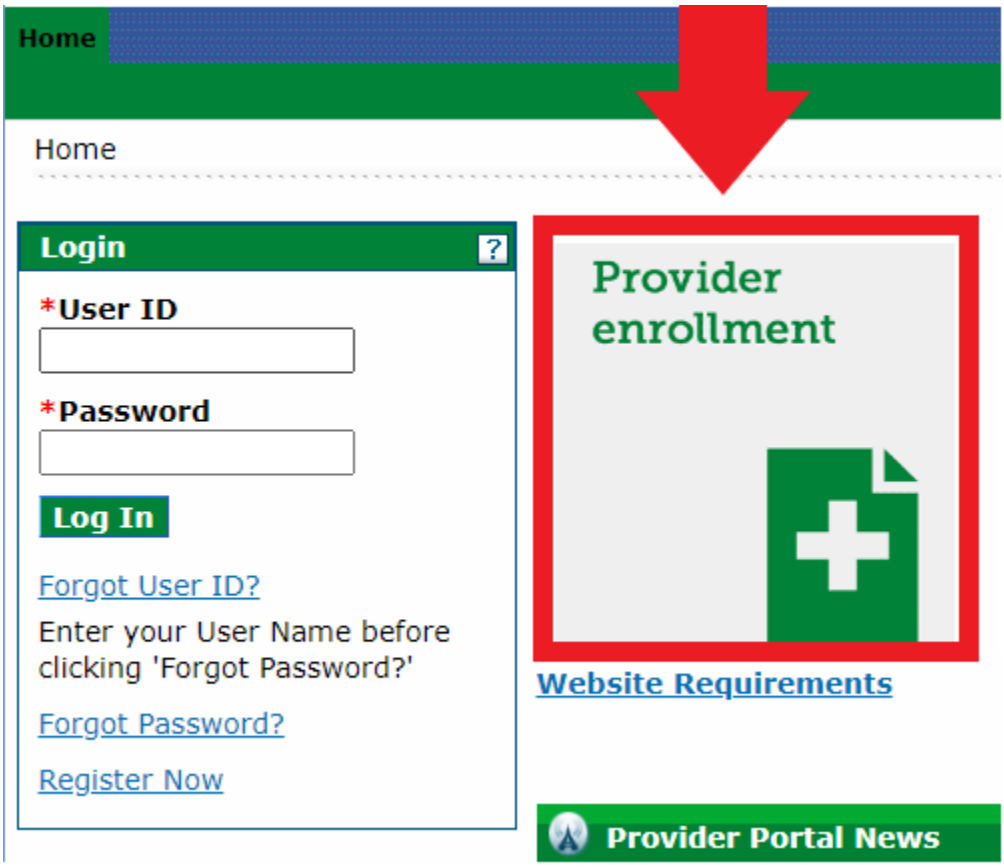
- During the revalidation review process, if additional information and/or missing documentation is needed, a notification email will be sent to the email address entered in the contact information. The applicant will then be able to return to the Revalidation application by logging in to the Provider Web Portal and selecting the Revalidation link. Once this is completed, the fiscal agent will be notified of the update and will continue processing.
- Once the application has been reviewed, an email notification will be sent to the address entered in the contact information advising the applicant of the outcome.
    - If the Revalidation application is approved, the user will be advised of the approval.
    - If the Revalidation application is rejected, the user will be advised of the reason. (See **File a Grievance** section for more information).

File a Grievance

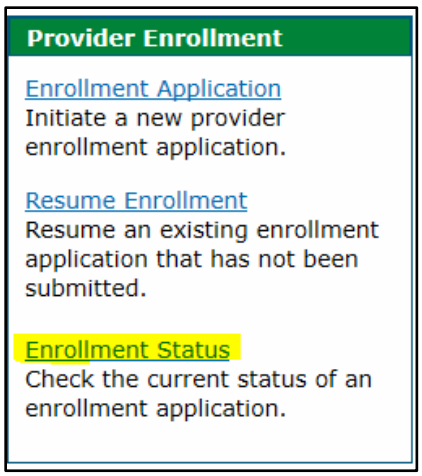
If the Revalidation application is rejected or denied, the user has the option to submit a new Revalidation ATN or they may file a grievance to have the application re-opened for processing. If the Revalidation ATN has been denied, and the revalidation link is selected, this will initiate a new Revalidation application. To have the denied application re-opened for processing the user may follow the below steps to submit a grievance.

1. Go to Provider Enrollment Portal Home page .

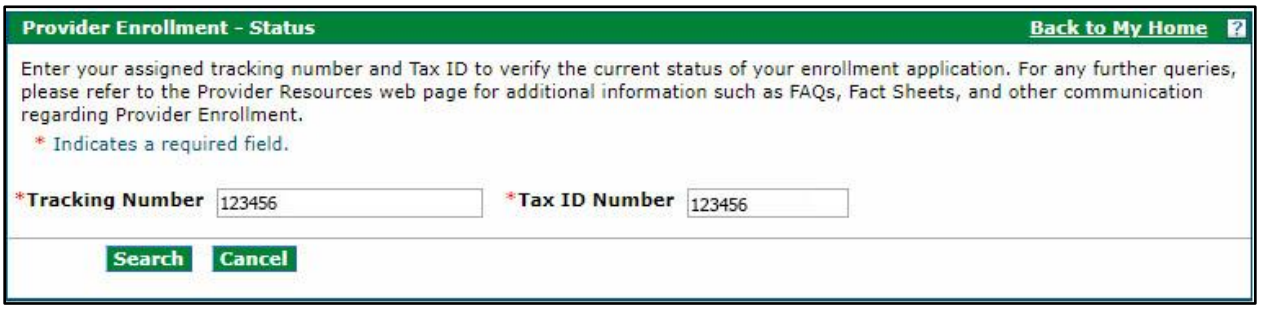
2. Select this box.



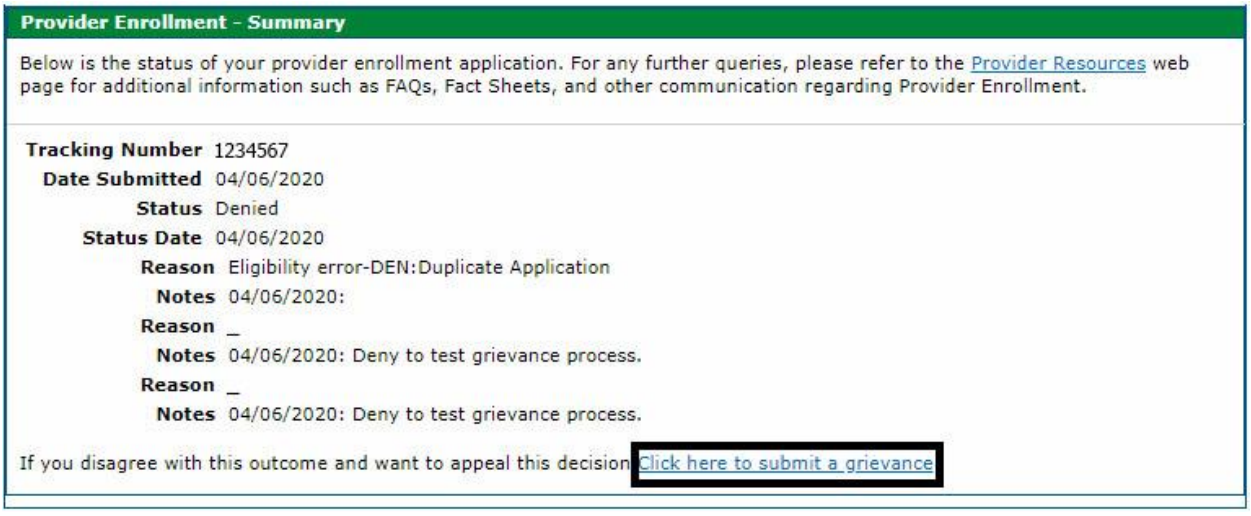
3. Select the Enrollment Status link.



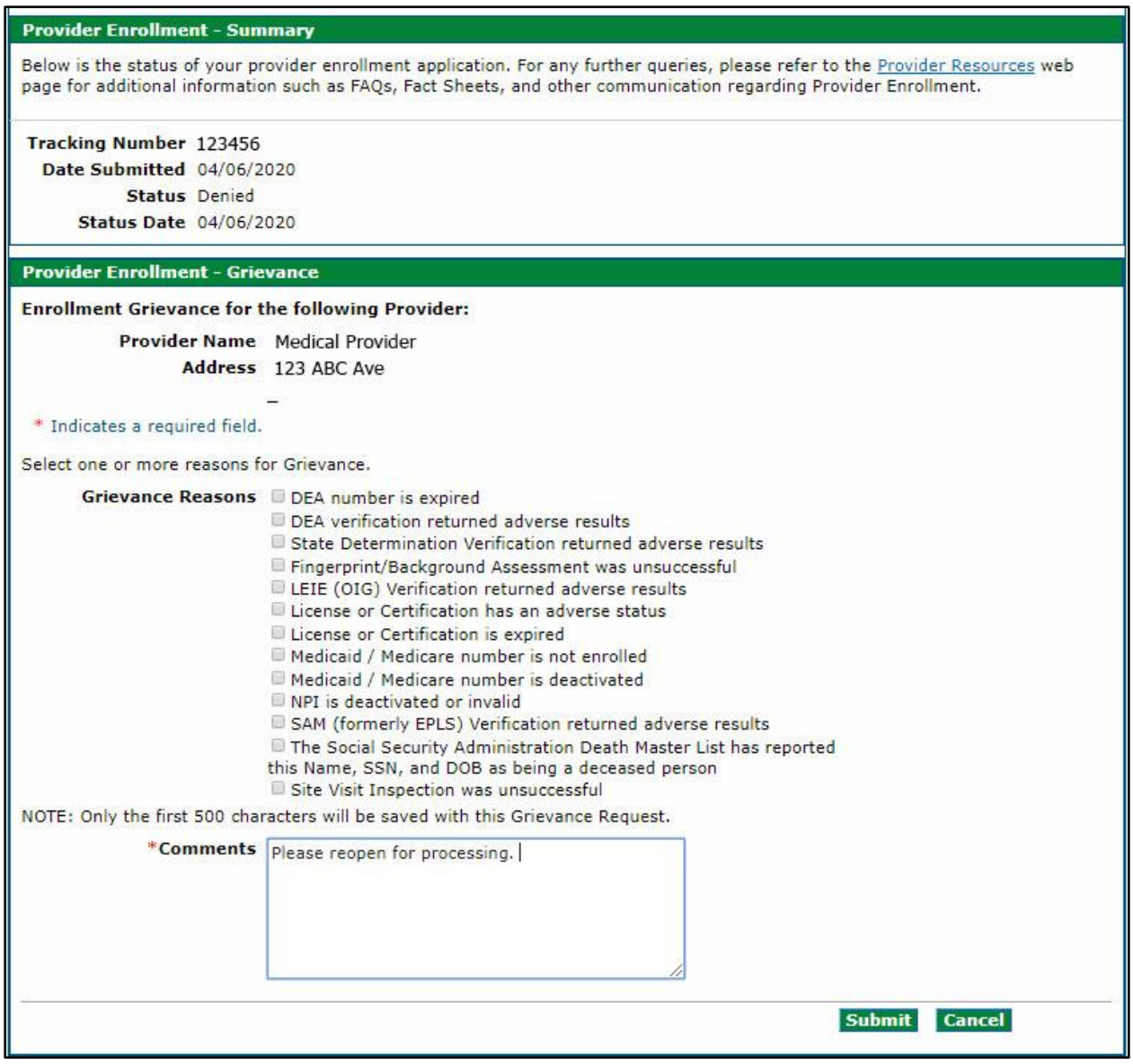
4. Enter the Application Tracking Number (ATN) and Tax ID number, then click the Search button.



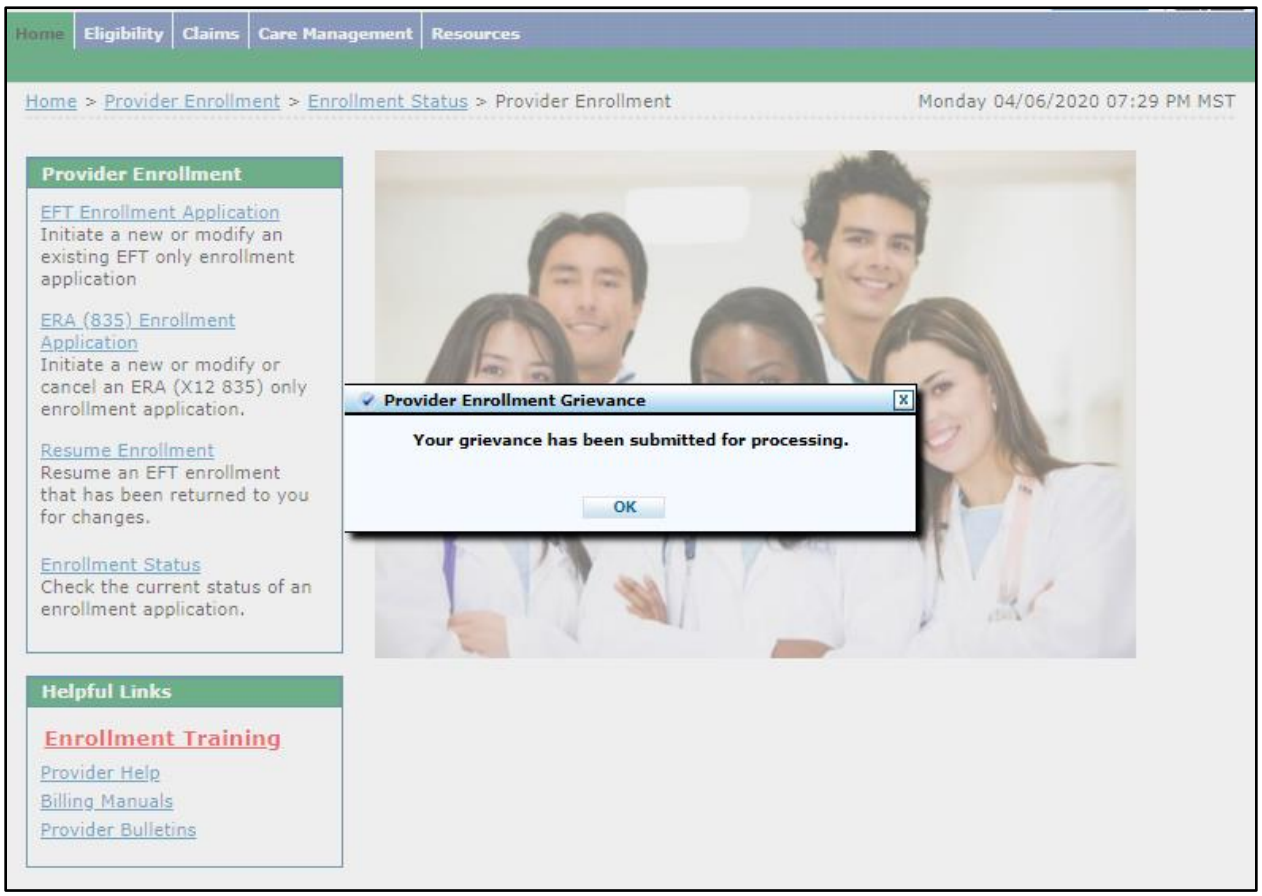
5. Scroll to the bottom of the page and select link 'Click here to submit a grievance'.



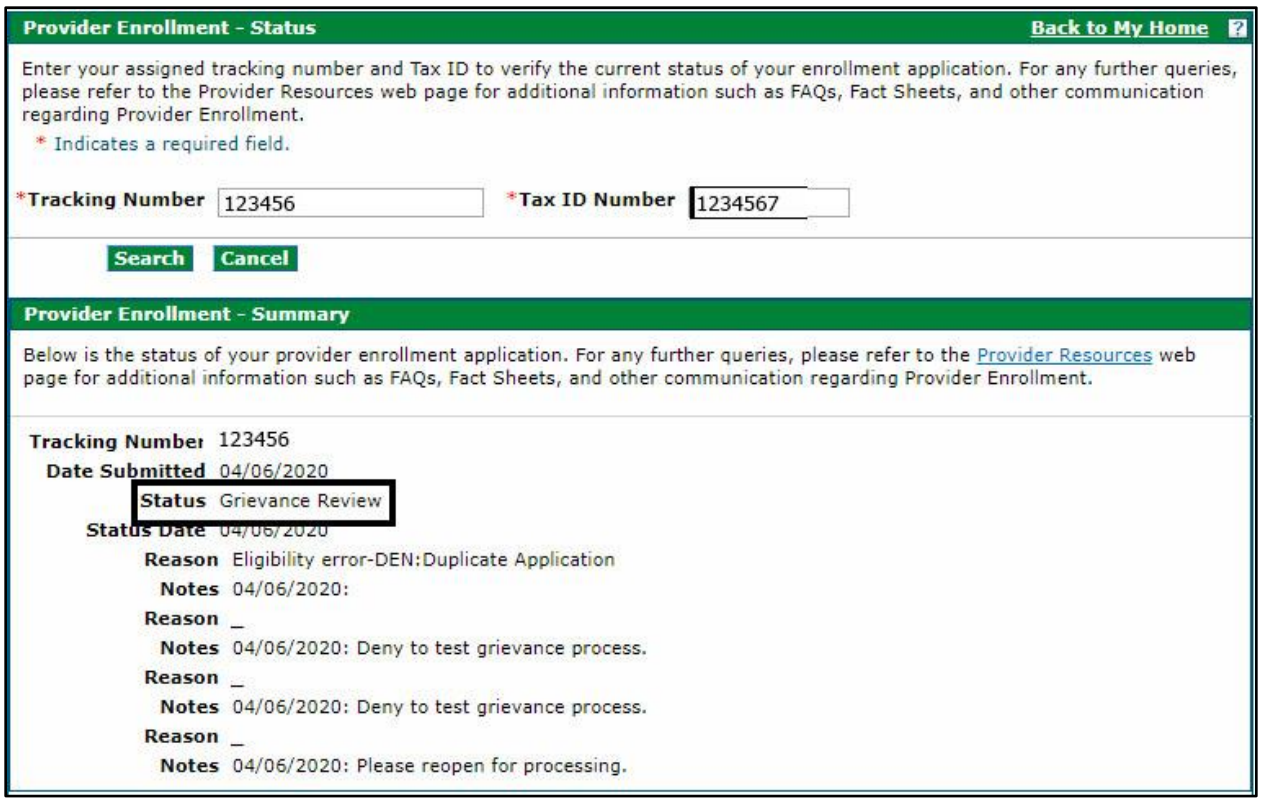
6. Enter the reason for disagreeing with the decision and click the Submit button.



7. The grievance has been filed.



The status will also change to reflect this.



8. Once the grievance is approved the Revalidation application is returned to an “Under Review” status. The application will be processed by an analyst and an email will be sent to the contact if there are any remaining issues.

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