



# Request to Submit Paper Claims

Complete this form to request paper claim submission.

## Provider Request

Provider ID Number: \_\_\_\_\_

Provider Name (Business or Individual): \_\_\_\_\_

Location Address: \_\_\_\_\_ Address Line 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**I attest that the provider will submit five (5) or less claims per month.**

*Provider/Provider Representative Name (please print):* \_\_\_\_\_

*Provider/Provider Representative Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Contact Information: Phone:* \_\_\_\_\_ *Email:* \_\_\_\_\_

**Complete form and mail to:  
Gainwell Technologies  
Attention: Provider Enrollment  
P.O. Box 30  
Denver, CO 80201**

Contact the Provider Call Center at 1-844-235-2387 for questions regarding Health First Colorado (Colorado’s Medicaid Program) enrollment.

Revised: November 2020

Improve health care equity, access and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado.

[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)

