COLORADO
Department of Health Care Policy & Financing

gainwell

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 Services Call Center for questions regarding Health First Colorado (Colorado's Medicaid Program) enrollment.

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