Third Party Reporting Form

For the purposes of coordinating third party liability, providers are asked to complete this form when a patient or his/her representative requests copies of bills for medical services paid by the Health First Colorado (Colorado’s Medicaid Program).

Complete the form and mail or fax:
Colorado Department of Health Care Policy & Financing
Benefits Coordination Section
1570 Grant Street
Denver, CO 80203
Fax: 303-866-3552

Today’s Date: ________________

Provider Name: ___________________________ Health First Colorado Provider ID: ___________________________

Member Information:
Name: ___________________________ Health First Colorado Program State ID: ___________________________
Home/Cell Phone Number: ______________ Work Phone Number: ___________________________
Address: __________________________________________
________________________________________________________

Dates of Service: ______________ Reason for Request: ___________________________

Party Requesting Information (if other than member):
Name: ___________________________ Relationship to Member: ___________________________
Home/Cell Phone Number: ___________________________
Address: __________________________________________
________________________________________________________

Revised: February 2021

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

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