COLORADO
Department of Health Care Policy & Financing

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

Provider Request

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