"BECOME A PROVIDER" FORM

Provider Relations Department
938 Bannock Street
Denver, CO 80204

Which lines of business are you interested in participating? (check all that apply):

- ○ Denver Health Medical Plan (DHMP)
- ○ Denver Health Medicaid Choice (DHMC)
- ○ DHMP Medicare Advantage

Provider Name (Last, First, Middle Initial) ______________________

Practice Name ______________________

Primary Office Address ______________________

City, State, Zip Code ______________________

Provider Phone # ______________________

Fax # ______________________

Email Address ______________________

Contact Name ______________________

Contact Phone # ______________________

Colorado License # ______________________

NPI ______________________

Specialty ______________________

Tax ID # ______________________

Are you Medicare Certified: ○ Yes ○ No If yes, Medicare #: ______________________

Are you Medicaid Certified: ○ Yes ○ No If yes, Medicaid #: ______________________

Additional information you would like to provide: ______________________

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PLEASE PROVIDE A COPY OF THE FOLLOWING:

- ○ Documentation of your Medicare and Medicaid participation, if applicable
- ○ A copy of your liability insurance
- ○ A list of any additional locations with NPI and Tax ID, if different
- ○ Current W-9
- ○ Any applicable accreditations

The Provider Relations Department will review your information and contact you with any further questions or concerns. Please make sure all information is complete so that we may properly process your request. Submit information and/or questions via email to ManagedCare.ProviderRelations@dhha.org, or via fax to 303-602-2516.