DENVER HEALTH MEDICAL PLAN INC.

'BECOME A PROVIDER' FORM

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

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

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 #

Medicare # | Medicaid #

Services Provided: _____

PLEASE PROVIDE A LIST OF ANY ADDITIONAL LOCATIONS WITH NPI AND TAX ID, IF DIFFERENT

The Provider Relations Department will only consider your request and contact you directly if there is a need for your services in the network. Please make sure all information is complete.
Submit information via email to: DHManagedCare_BecomeaProvider@dhha.org

DHHA INTERNAL USE ONLY:

Date of Request: _____

Requester Name: _____

Requester Phone Number: _____

Requester Email: _____

Provider/Vendor Requesting: _____

Contract Consideration: _____

Services Provided: _____

Problem Statement: _____

Issue Resolution Description: _____

Benefits: _____