Letter of Attestation – Authorization of Medicaid State Portal Access

By providing the required information and my signature below, I certify my understanding that I will be granted access to the State of Colorado Healthcare Policy and Finance (HCPF) Medicaid Portal. With that access, I attest that I will only utilize the portal to verify Medicaid eligibility for prospective/current members for the Denver Health Medical Plan, Inc. Any misuse of the portal may result in revocation of access.

Name: _____

Date of Birth: _____

Last 4 Digits of Driver License or State ID: _____

_____
Signature

_____
Date