

Thank you for your interest in joining our network!
Please fill out the form below and attach your W9.
Email both items to: DHManagedCare_BecomeAProvider@dhha.org

Is there a completed contract with Denver Health Medical Plan (DHMP)?

- ☐ Yes ([click here for credentialing form](#)) ☐ No (please complete below)

Which line(s) of business are you interested in participating in?

- ☐ Elevate Medicare Advantage
☐ Elevate Medicaid Choice
☐ Elevate Child Health Plan Plus (CHP+)
☐ Elevate Exchange/CO Option
☐ DHHA Employer Group

How many practitioners will be affiliated with the contract?

- ☐ 1 (single entity) ☐ 2 - 15 ☐ 16 or more

Will you need to have practitioners or facilities credentialed by DHMP?

- ☐ Yes
☐ DHMP will credential
☐ You will perform credentialing through a delegated agreement with DHMP
☐ No

Are you approved with Colorado Medicaid?

- ☐ Yes ☐ No

Contracting Information for Provider/Organization

Provider/Organization		Organization NPI #
Business Website		Organization TIN #
Primary Address		
City	State	Zip
Phone #		Fax #
Contact First Name		Contact Last Name
Contact Email		
Average Wait Time(s) for New Patients		
Location(s) in Colorado		
Specialty or Taxonomy Code(s)		

**Thank you for your inquiry to join our network.
After a diligent review process, we will reach back out.
This process could take up to 120 days.**