COLORADO OUT-OF-NETWORK AMBULANCE CLAIM ATTESTATION FORM

Appendix "A"
Denver Health Medical Plan Provider Attestation Form
For HB 19-1174 and Colorado Regulation 4-2-66 Consideration

DIRECTIONS:
Complete this form in its entirety and **mail to the address listed below.**

I hereby attest that:

Provider's Name: _____

Tax ID #: _____ NPI #: _____

and located at _____

qualifies for non-participating rates per
Colorado Regulation 4-2-66 & HB 19-1174.

Provider CEO Name: _____

Provider CEO Signature: _____

Provider TIN: _____

Signature: _____ Date: _____

MAIL FORM TO:
Denver Health Medical Plan, Inc.
P.O. Box 6300
Columbia, MD 21045