APPENDIX 1 (Professional Provider Agreement Application)

Complete all applicable boxes and put N/A in any boxes left blank.

Attach the following and return with completed appendix to provider.contracting@coaccess.com:
IRS W-9
Copy of Professional Liability Insurance
CLIA Certification (If applicable)

Legal name: (As registered with the Secretary of State)	
DBA/Directory listing name: (If applicable)	
Office contact name and title:	**Email address:**
Contract Signature of Authority:(who will sign the contract?)	**Email address:**
Phone:	**Fax:**
Website address:	

Please mark all that apply to practice:

Practice is female-owned ☐
(Optional)

Practice is minority-owned ☐
(Optional)

Practice is telehealth only ☐

Practice provides a HIPAA compliant, private/secure location to render telehealth services ☐

Practice provides American Sign Language (ASL) services ☐

Federally Qualified Health Center (FQHC) ☐

Rural Health Center (RHC) ☐

Community Mental Health Center (CMHC) ☐

Pediatric only ☐

Women only ☐

Adults only ☐

Capable of billing Medicare ☐

Capable of billing Medicaid ☐

Continued on next page

Please indicate which medical home accreditations, if any, have been awarded to your practice by any of the following agencies:

Accreditation Association for Ambulatory Health Care (AAAHC) ☐ **What year?** _____

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) ☐ **What year?** _____

National Committee for Quality Assurance (NCQA) ☐ **What year?** _____

Utilization Review Accreditation Commission (URAC) ☐ **What year?** _____

Ages seen in your practice (please mark all that apply):

☐ 0-1	☐ 14-18	☐ 26-50
☐ 2-5	☐ 19-20	☐ 51-64
☐ 6-13	☐ 21-25	☐ 65+

Make checks payable to (Box 33 of CMS 1500 form)**:** ☐ Legal Name (must have an organizational NPI for this option) ☐ DBA Name (must have an organizational NPI for this option) ☐ Individual Provider	
Federal tax ID (TIN):	**Organizational NPI #:**
Organizational Medicaid #:	**Organizational Medicare #:**
Billing/remit address, city, state, zip code:	
Mailing address, city, state, zip code:	
County:	
Billing contact name:	**Billing phone:**
Billing fax:	
Billing contact email address:	

Billing Format: **CMS 1500** ☐ **UB04** (FQHCs and Facilities only. Clinics must bill using CMS 1500) ☐
Directory: **Yes** ☐ **No** ☐

APPENDIX 1 (Continued)

Complete for each PRACTICE/SITE location included in this Agreement.

Please copy this page if necessary, in order to complete for each practice/site location.

(1- Primary) Do you have multiple sites? Yes ☐ No ☐ If yes, how many? **Practice site location name:**			
Address, City, State, Zip Code:			
County:			
NPI:	**TIN:**	**Phone:**	**Fax:**
Site-specific Medicaid ID:	**Enrollment limit?** **Yes ☐ No ☐**	If yes, list maximum # of Medicaid members:	

Office Hours: (add your hours of operation for each day of the week, indicating AM or PM)

☐	Mon	**to**		☐	Fri	**to**	
☐	Tues	**to**		☐	Sat	**to**	
☐	Wed	**to**		☐	Sun	**to**	
☐	Thurs	**to**					

ADA Compliance:

Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage?	**Yes ☐**	**No ☐**
Are any of the parking spaces van-accessible?	**Yes ☐**	**No ☐**
Do you have an accessible examination room for individuals with disabilities?	**Yes ☐**	**No ☐**
Do you have accessible medical equipment to accommodate examining individuals with disabilities?	**Yes ☐**	**No ☐**
Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities?	**Yes ☐**	**No ☐**

Continued on next page

(2) Practice/site location name:

Address, City, State, Zip Code:

County:

NPI:	**TIN**	**Phone:**	**Fax:**
Site-specific Medicaid ID:	**Enrollment limit?** **Yes** ☐ **No** ☐	If yes, list maximum # of Medicaid members:	

Office Hours: (add your hours of operation for each day of the week, indicating AM or PM)

☐	Mon	**to**		☐	Fri	**to**	
☐	Tues	**to**		☐	Sat	**to**	
☐	Wed	**to**		☐	Sun	**to**	
☐	Thurs	**to**					

ADA Compliance:

Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage? **Yes** ☐ **No** ☐

Are any of the parking spaces van-accessible? **Yes** ☐ **No** ☐

Do you have an accessible treatment room or office for individuals with disabilities? **Yes** ☐ **No** ☐

Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities? **Yes** ☐ **No** ☐

(3) Practice/site location name:

Address, City, State, Zip Code:

County:

NPI:	**TIN**	**Phone:**	**Fax:**
Site-specific Medicaid ID:	**Enrollment limit?** **Yes** ☐ **No** ☐	If yes, list maximum # of Medicaid members:	

Office Hours: (add your hours of operation for each day of the week, indication AM or PM)

☐	Mon	**to**		☐	Fri	**to**	
☐	Tues	**to**		☐	Sat	**to**	
☐	Wed	**to**		☐	Sun	**to**	
☐	Thurs	**to**					

ADA Compliance:

Is there an ADA accessible approach (e.g., ramps, stability, curbs, stairs, width, etc.) to the entrance of your building/office, with accessible parking spaces that are identified with signage? **Yes** ☐ **No** ☐

Are any of the parking spaces van-accessible? **Yes** ☐ **No** ☐

Do you have an accessible treatment room or office for individuals with disabilities? **Yes** ☐ **No** ☐

Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities? **Yes** ☐ **No** ☐

APPENDIX 1 (Continued)

Please complete for each individual licensed practitioner (physicians and non-physician practitioners) included in this Agreement and indicate all site locations where practitioner will be providing services.

Please copy this page if necessary, in order to complete for each individual practitioner.

Full name:	**Date of birth:**	**Degree/licensures:**	**Practicing specialty:**
Subspecialty:		**Primary taxonomy code:**	
Secondary taxonomy code:		**Medication Assistance Treatment (MAT) certified:** **Yes** ☐ **No** ☐	
Medicare ID #:	**Medicaid ID #:**	**Individual NPI #:** (Box 24J of the CMS 1500 form):	**CAQH #:**
Additional languages spoken:		**Accepting new patients:** **Yes** ☐ **No** ☐	
Interpretive services provided: **Yes** ☐ **No** ☐			
Provider gender (optional)**:** **Female** ☐ **Male** ☐			
Has completed cultural competency training? **Yes** ☐ **Date:** **No** ☐ **Training provided by:** (offered online through Colorado Access) – attach certificate of completion for non-Colorado Access training			
Practice site location(s) from previous pages:			
Is provider practicing only in an inpatient/hospitalist capacity? **Yes** ☐ **No** ☐		**Are services provided only in nursing or hospital facilities?** **Yes** ☐ **No** ☐	

Full name:	**Date of birth:**	**Degree/licensures:**	**Practicing specialty:**
Subspecialty:		**Primary taxonomy code:**	
Secondary taxonomy code:		**Medication Assistance Treatment (MAT) certified:** **Yes** ☐ **No** ☐	
Medicare ID #:	**Medicaid ID #:**	**Individual NPI #:** (Box 24J of the CMS 1500 form):	**CAQH #:**
Additional languages spoken (list all):		**Accepting new patients:** **Yes** ☐ **No** ☐	
Interpretive services provided: **Yes** ☐ **No** ☐ **Languages:**			
Provider gender (optional): **Female** ☐ **Male** ☐			

Has completed cultural competency training? **Yes** ☐ **Date:** **No** ☐ **Training provided by:** (offered online through Colorado Access) – attach certificate of completion for non-Colorado Access training	
Practice site location(s) from previous pages:	
Is provider practicing only in an inpatient/hospitalist capacity? **Yes** ☐ **No** ☐	**Are services provided only in nursing or hospital facilities?** **Yes** ☐ **No** ☐

Full name:	**Date of birth:**	**Degree/licensures:**	**Practicing specialty:**
Subspecialty:		**Primary taxonomy code:**	
Secondary taxonomy code:		**Medication Assistance Treatment (MAT) certified:** **Yes** ☐ **No** ☐	
Medicare ID #:	**Medicaid ID #:**	**Individual NPI #:** (Box 24J of the CMS 1500 form):	**CAQH #:**
Additional languages spoken:		**Accepting new patients:** **Yes** ☐ **No** ☐	
Interpretive services provided: **Yes** ☐ **No** ☐			
Provider gender (optional)**:** **Female** ☐ **Male** ☐			
Has completed cultural competency training? **Yes** ☐ **Date:** **No** ☐ **Training provided by:** (offered online through Colorado Access) – attach certificate of completion for non-Colorado Access training			
Practice site location(s) from previous pages:			
Is provider practicing only in an inpatient/hospitalist capacity? **Yes** ☐ **No** ☐		**Are services provided only in nursing or hospital facilities?** **Yes** ☐ **No** ☐	
Does any other Individual have an Ownership or Control Interest in Provider's business? **Yes** ☐ **No** ☐			
If your answer is **YES**, please list all such individuals with an ownership or control interest in the applicant. Include each person's name, address, date of birth (DOB), and Social Security Number (SSN). Also indicate the title (e.g. chief executive officer, owner) and if an owner, the percent of ownership. Please see the definition of "persons with an ownership or control interest" to ensure that all individuals are included. Attach additional pages as needed.			

Name	Title	% of ownership (if applicable)	Address	DOB	SSN

Does any other Corporation have an Ownership or Control Interest in Provider?	**Yes** ☐	**No** ☐

If your answer is YES, please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the primary business address, every business location, and P.O. Box address(es). Attach additional pages as needed.

Name of Corporation	TIN	% of ownership (if applicable)	Primary Business Address	Every Business Location	PO Box Addresses

For purposes of the above Questions, "**Person/Corporation with an ownership or control interest**" means a person or corporation that:

a) Has an ownership interest totaling 5 percent or more in Provider;
b) Has an indirect ownership interest equal to 5 percent or more in Provider;
c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in Provider;
d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by Provider if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
e) Is an officer or director of Provider that is organized as a corporation; **or**
f) Is a partner in a Provider that is organized as a partnership?

Attestation:

All information provided on this application or in connection with this application is complete, truthful and accurate to the best of Provider's knowledge.

Provider further agrees to notify Colorado Access in a timely manner of any changes to the information provided on the application, including any Medicare and Medicaid sanctions or remedies imposed by the State.

Provider further certifies that the medical and/or clinical staff is legally and professionally qualified for the positions to which they are appointed and that the organization credentials its individual practitioners.

Signature:_____

Print Name:_____

Title:_____

Organization (if applicable):_____

Date:_____

Behavioral Health Specialty

Please indicate which specialty population you work with below:

- ☐ Children (12 and younger)
- ☐ Adolescents (13 to 18)
- ☐ Foster Care
- ☐ Adults (19 to 64)
- ☐ Seniors (65 and older)

Treatment modalities:

- ☐ Aggression Replacement Therapy
- ☐ Animal-assisted
- ☐ Art Therapy
- ☐ Attachment-based Therapy
- ☐ Biofeedback
- ☐ Cognitive Behavioral Therapy
- ☐ Dialectical Behavior Therapy
- ☐ Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- ☐ Exposure and Response Prevention
- ☐ Habit Reversal Therapy
- ☐ Multisystemic Therapy (MST)
- ☐ Psychological Testing and Evaluation
- ☐ Play Therapy
- ☐ Sex Offender Management Board (SOMB Treatment Provider)
- ☐ Other:

Please check only the top 10 specialty(s) of your practice below:

- ☐ Adoption
- ☐ AIDS/HIV
- ☐ Alzheimer's/dementia
- ☐ Anxiety/panic
- ☐ AIDS/HIV
- ☐ ADD/ADHD
- ☐ Autism Spectrum
- ☐ Bipolar disorder
- ☐ Borderline Personality Disorder
- ☐ Brain Injury (TBI)
- ☐ Child abuse
- ☐ Children of alcoholics
- ☐ Chronic pain or illness
- ☐ Compulsive behaviors
- ☐ Conduct disorder
- ☐ Criminal justice
- ☐ Cultural issues
- ☐ Depression
- ☐ Developmental disorders
- ☐ Disruptive behavior disorders
- ☐ Dissociative disorders
- ☐ Divorce/custody
- ☐ Domestic violence
- ☐ Eating disorders
- ☐ Elder abuse
- ☐ End-of-life
- ☐ Family therapy
- ☐ Gender identity counseling
- ☐ Grief and loss
- ☐ Impulse control
- ☐ Intellectual disabilities
- ☐ Intimacy issues
- ☐ LGBTQ counseling
- ☐ Learning disabilities
- ☐ Life transitions
- ☐ Men's issues
- ☐ Mental Health Certifications designated by the Office of Behavioral Health (OBH)
- ☐ Mood disorders
- ☐ Neuropsychiatry
- ☐ Neuropsychology
- ☐ Obesity
- ☐ Obsessive compulsive disorders
- ☐ Parenting issues
- ☐ Personality Disorders
- ☐ Phobias
- ☐ Postpartum
- ☐ Post-traumatic stress
- ☐ Psychological illness
- ☐ Psychosis
- ☐ Psychosomatic illness
- ☐ Queer/Questioning
- ☐ Relationship issues
- ☐ Relinquishment counseling
- ☐ Reproductive
- ☐ Schizophrenia
- ☐ Self-harm/self-injury
- ☐ Sexual harassment
- ☐ Sexual issues
- ☐ Sexual offenders
- ☐ Sleep/insomnia
- ☐ Spiritual concerns
- ☐ Stress management
- ☐ Substance Use Disorder
- ☐ Trauma
- ☐ Violent offenders
- ☐ Women's issues
- ☐ Other: