

APPENDIX 1 (Facility/Ancillary Provider Agreement)

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 <input type="checkbox"/> (Optional)	
Practice is minority-owned <input type="checkbox"/> (Optional)	
Practice is telehealth only <input type="checkbox"/>	
Practice provides a HIPAA compliant, private/secure location to render telehealth services <input type="checkbox"/>	
Practice provides American Sign Language (ASL) services <input type="checkbox"/>	
Federally Qualified Health Center (FQHC) <input type="checkbox"/>	
Rural Health Center (RHC) <input type="checkbox"/>	
Community Mental Health Center (CMHC) <input type="checkbox"/>	
Pediatric only <input type="checkbox"/>	
Women only <input type="checkbox"/>	
Adults only <input type="checkbox"/>	
Capable of billing Medicare <input type="checkbox"/>	
Capable of billing Medicaid <input type="checkbox"/>	

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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		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	<input type="checkbox"/>	No <input type="checkbox"/>
Are any of the parking spaces van-accessible?				Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Do you have an accessible examination room for individuals with disabilities?				Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Do you have accessible medical equipment to accommodate examining individuals with disabilities?				Yes	<input type="checkbox"/>	No <input type="checkbox"/>
Are you able to effectively communicate with individuals who have hearing, vision, speech or cognitive disabilities?				Yes	<input type="checkbox"/>	No <input type="checkbox"/>

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(2) Practice/site location name:

Address, City, State, Zip Code:

County:

NPI:	TIN	Phone:	Fax:
Site-specific Medicaid ID:	Enrollment limit? Yes <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/> No <input type="checkbox"/>	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 <input type="checkbox"/> No <input type="checkbox"/>	
Medicare ID #:	Medicaid ID #:	Individual NPI #: (Box 24J of the CMS 1500 form):		CAQH #:
Additional languages spoken:			Accepting new patients: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Interpretive services provided: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Provider gender (optional): Female <input type="checkbox"/> Male <input type="checkbox"/>				
Has completed cultural competency training? Yes <input type="checkbox"/> Date: No <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/>			Are services provided only in nursing or hospital facilities? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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

Behavioral Health Specialty

Please indicate which specialty population you work with below:

- | | |
|--|---|
| <input type="checkbox"/> Children (12 and younger) | <input type="checkbox"/> Adults (19 to 64) |
| <input type="checkbox"/> Adolescents (13 to 18) | <input type="checkbox"/> Seniors (65 and older) |
| <input type="checkbox"/> Foster Care | |

Treatment modalities:

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

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

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