

# 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](mailto:provider.contracting@coaccess.com):

IRS W-9

Copy of Professional Liability Insurance

CLIA Certification (If applicable)

<b>Legal name:</b> (As registered with the Secretary of State)	
<b>DBA/Directory listing name:</b> (If applicable)	
<b>Office contact name and title:</b>	<b>Email address:</b>
<b>Contract Signature of Authority:</b> (who will sign the contract?)	<b>Email address:</b>
<b>Phone:</b>	<b>Fax:</b>
<b>Website address:</b>	
<b>Please mark all that apply to the practice:</b>	
<i>Colorado Access does not discriminate regardless of race, color, national origin, age, sex, genetic information, religion, pregnancy, disability, sexual orientation, veteran status, or any other status protected by applicable law.</i>	
The information below will help Colorado Access inform its diverse membership of the providers in our network and help them make a choice in providers that best serves them and will not be used for any other purpose. You are not required to answer the optional questions below.	
Practice is owned by a woman <input type="checkbox"/>	
Practice is owned by a person of color (Black, Indigenous, Asian/Pacific Islander, LatinX) <input type="checkbox"/> If yes, please specify: _____	
Practice is owned by a veteran <input type="checkbox"/>	
Practice is owned by a veteran who is differently abled <input type="checkbox"/>	
Practice is owned by a person who is differently abled <input type="checkbox"/>	
Practice is 100% telehealth <input type="checkbox"/>	
Community Mental Health Center (CMHC) <input type="checkbox"/>	
Substance Use Disorder clinic <input type="checkbox"/>	
Indian Health Care Provider (IHCP) <input type="checkbox"/>	
Essential Community Provider (ECP) <input type="checkbox"/>	
School-Based Health Center (SBHC) <input type="checkbox"/>	

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)

Pediatric only

Women only

Adults only

Capable of billing Medicare

Capable of billing Medicaid

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? \_\_\_\_\_

Continued on next page



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

- |                               |                                |                                |
|-------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 0-1  | <input type="checkbox"/> 14-18 | <input type="checkbox"/> 26-50 |
| <input type="checkbox"/> 2-5  | <input type="checkbox"/> 19-20 | <input type="checkbox"/> 51-64 |
| <input type="checkbox"/> 6-13 | <input type="checkbox"/> 21-25 | <input type="checkbox"/> 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.

<b>(1- Primary) Do you have multiple sites? Yes <input type="checkbox"/> No <input type="checkbox"/></b> If yes, how many? <b>Practice site location name:</b>								
<b>Does your practice provide care for underserved or special populations? Yes <input type="checkbox"/> No <input type="checkbox"/></b> If yes, please list:								
<b>Address, City, State, Zip Code:</b>								
<b>County:</b>								
<b>NPI:</b>		<b>TIN:</b>		<b>Phone:</b>		<b>Fax:</b>		
<b>Site-specific Medicaid ID:</b>		<b>Enrollment limit?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list maximum # of Medicaid members:						
<b>Office Hours: (add your hours of operation for each day of the week, indicating AM or PM)</b>								
	Mon	to			Fri	to		
	Tues	to			Sat	to		
	Wed	to			Sun	to		
	Thurs	to						
<b>Does the practice provide 24/7 phone coverage with access to a clinician that can triage the member's health need?</b>							Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>ADA Compliance:</b>								
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"/>

Continued on next page



<b>(2) Practice/site location name:</b>			
<b>Address, City, State, Zip Code:</b>			
<b>County:</b>			
<b>NPI:</b>	<b>TIN</b>	<b>Phone:</b>	<b>Fax:</b>
<b>Site-specific Medicaid ID:</b>	<b>Enrollment limit?</b> 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					

**Does the practice provide 24/7 phone coverage with access to a clinician that can triage the member's health need?** Yes  No

**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



<b>(3) Practice/site location name:</b>							
<b>Address, City, State, Zip Code:</b>							
<b>County:</b>							
<b>NPI:</b>		<b>TIN</b>		<b>Phone:</b>		<b>Fax:</b>	
<b>Site-specific Medicaid ID:</b>		<b>Enrollment limit?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list maximum # of Medicaid members:					
<b>Office Hours: (add your hours of operation for each day of the week, indication AM or PM)</b>							
	Mon	to			Fri	to	
	Tues	to			Sat	to	
	Wed	to			Sun	to	
	Thurs	to					
<b>Does the practice provide 24/7 phone coverage with access to a clinician that can triage the member's health need?</b>						Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>ADA Compliance:</b>							
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 treatment room or office for 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"/>



## 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.

*Colorado Access does not discriminate regardless of race, color, national origin, age, sex, genetic information, religion, pregnancy, disability, sexual orientation, veteran status, or any other status protected by applicable law.*

Full name:		Date of birth:	Degree/licensure:	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"/>	
My clients include: (mark all that apply) Males <input type="checkbox"/> Females <input type="checkbox"/> Trans <input type="checkbox"/> Other <input type="checkbox"/>				
Interpretive services provided: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Provider gender: Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/>				
Provider race:			Provider ethnicity:	
Provider gender pronouns:				
Has completed cultural competency responsiveness training? Yes <input type="checkbox"/> Date: _____ No <input type="checkbox"/>				
Training provided by Colorado Access: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, provide name of training and by whom:				
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"/>	



<b>Full name:</b>		<b>Date of birth:</b>	<b>Degree/licensures:</b>	<b>Practicing specialty:</b>
<b>Subspecialty:</b>			<b>Primary taxonomy code:</b>	
<b>Secondary taxonomy code:</b>			<b>Medication Assistance Treatment (MAT) certified:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Medicare ID #:</b>	<b>Medicaid ID #:</b>	<b>Individual NPI #:</b> (Box 24J of the CMS 1500 form):		<b>CAQH #:</b>
<b>Additional languages spoken (list all):</b>			<b>Accepting new patients:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>My clients include:</b> (mark all that apply) Males <input type="checkbox"/> Females <input type="checkbox"/> Trans <input type="checkbox"/> Other <input type="checkbox"/>				
<b>Interpretive services provided:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Languages:</b>				
<b>Provider gender:</b> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/>				
<b>Provider race:</b>			<b>Provider ethnicity:</b>	
<b>Provider gender pronouns:</b>				
<b>Has completed cultural competency responsiveness training?</b> Yes <input type="checkbox"/> Date: _____ No <input type="checkbox"/>				
<b>Training provided by Colorado Access:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, provide name of training and by whom:				
<b>Practice site location(s)</b> from previous pages:				
<b>Is provider practicing only in an inpatient/hospitalist capacity?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>			<b>Are services provided only in nursing or hospital facilities?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>Full name:</b>		<b>Date of birth:</b>	<b>Degree/licensures:</b>	<b>Practicing specialty:</b>
<b>Subspecialty:</b>			<b>Primary taxonomy code:</b>	
<b>Secondary taxonomy code:</b>			<b>Medication Assistance Treatment (MAT) certified:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Medicare ID #:</b>	<b>Medicaid ID #:</b>	<b>Individual NPI #:</b> (Box 24J of the CMS 1500 form):		<b>CAQH #:</b>
<b>Additional languages spoken:</b>			<b>Accepting new patients:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>My clients include:</b> (mark all that apply) Males <input type="checkbox"/> Females <input type="checkbox"/> Trans <input type="checkbox"/> Other <input type="checkbox"/>				
<b>Interpretive services provided:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				



Provider gender: Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/>					
Provider race:			Provider ethnicity:		
Provider gender pronouns:					
Has completed cultural competency responsiveness training? Yes <input type="checkbox"/> Date: _____ No <input type="checkbox"/>					
Training provided by Colorado Access: Yes <input type="checkbox"/> No <input type="checkbox"/> If no, provide name of training and by whom:					
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"/>		
Does any other Individual have an Ownership or Control Interest in Provider's business? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If your answer is <b>YES</b> , 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 <input type="checkbox"/> No <input type="checkbox"/>					
If your answer is <b>YES</b> , 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:

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

Treatment modalities:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Aggression Replacement Therapy | <input type="checkbox"/> Dialectical Behavior Therapy                                    | <input type="checkbox"/> Multisystemic Therapy (MST)                                |
| <input type="checkbox"/> Animal-assisted                | <input type="checkbox"/> Eye Movement Desensitization<br>and Reprocessing Therapy (EMDR) | <input type="checkbox"/> Psychological Testing<br>and Evaluation                    |
| <input type="checkbox"/> Art Therapy                    | <input type="checkbox"/> Exposure and Response<br>Prevention                             | <input type="checkbox"/> Play Therapy   |
| <input type="checkbox"/> Attachment-based Therapy       | <input type="checkbox"/> Habit Reversal Therapy  | <input type="checkbox"/> Sex Offender Management Board<br>(SOMB Treatment Provider) |
| <input type="checkbox"/> Biofeedback                    |  |   |
| <input type="checkbox"/> Cognitive Behavioral 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<br>designated by the Office of<br>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"/> Divorce/custody                 | <input type="checkbox"/> Postpartum   |  |
| <input type="checkbox"/> Domestic violence               |   |  |
| <input type="checkbox"/> Eating disorders                |   |  |