

Using Clinical Update Forms



Using Clinical Update Forms

Definitions:

- Colorado Access (COA)
- Credentialing required - Practitioners providing outpatient services
- Employer Identification Number (EIN)
- National Provider ID (NPI)
- National Plan & Provider Enumeration System (NPPES)
- Tax Identification Number (TIN)

Procedures:

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1. High-Level Overview

The new practitioner, clinic, and facility update forms are online [here](#).

Click the drop-down arrow for the “**Clinical Request Type**” to select what the request is for.

These forms are for all entities that are **contracted with us**. If you are not contracted and would like to be, please email provider.contracting@coaccess.com. If you submit a form and are not a contracted entity, we will not be able to process your request.

Please ensure the office contact email address is accurately entered. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Please ensure the NPI is validated with the state of Colorado. If the NPI is not validated, even though we have made the requested updates in our systems, the claims will be denied for non-validation.

Some data fields default to today’s date, please ensure the date is accurate after going to the next field.

Some of these forms will be automatically loaded into our systems, so it’s important that the information is accurately entered. **If there are data mismatches** between NPI and name, the **data will not load** and may be rejected.

When data is submitted accurately, you will experience a faster turnaround time on your request. All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

Please note, although the reference number shows the submission is completed, it does not mean that that credentialing has also been completed. If credentialing is required, a separate notification will be sent once credentialing is completed.

Colorado Access does not discriminate, or base credentialing decisions, on an applicant's race, ethnicity, or language. Providing this information is optional.

2. Clinical Staff Add Physical Health

The “Clinical Staff Add Physical Health” form is used to add individual practitioners to already contracted entities.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Main Office Information

Main Office Information

Office's Legal Name:*

Tax ID Number (SSN/EIN)*

No dashes, 9 digits only

Enter the main office legal name for this practitioner.

The tax ID entered should match the W-9 information used in the billing loop.

Provider Information

Provider Information

Provider NPI*

Provider First Name*

Provider MI

Provider Last Name*

Provider Date of Birth*

Please enter the providers date of birth mm/dd/yyyy

Gender

F M X Other

The provider information section collects the data for the individual practitioner that will be loaded into our systems.

The provider NPI that is entered must match the submitted provider name. If the NPI and name do not match according to the state validation report and/or NPPES, the request will be denied, and you will need to resubmit your request with the correct information.

Please also ensure the NPI is validated with the state of Colorado. If the NPI is not validated, even though we have made the requested updates in our systems, the claims will be denied for non-validation, and if required, credentialing will not be started.

Degree/Suffix*
i.e. MD, LPC, SLP, etc. Choose all that apply

CAQH# (please ensure profile is current)

<https://proview.caqh.org/Login?Type=PR>

Practicing Specialty

Select "Degree/Suffix" from the drop-down menu.

If there is a CAQH number, please include that information. This will be used if credentialing is required. Please also indicate the practicing specialty, although this is not required.

Effective Date of Change*

If date is unknown, select today's date

Feb 27, 2025

The effective date of change will default to today's date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Is provider practicing ONLY in an inpatient/hospitalist or locum tenens capacity?*

Select..

Use the drop-down menu to indicate if the individual practitioner is practicing ONLY in an inpatient/hospitalist or locum tenens capacity.

Affiliate provider with all locations NPIs under this tax ID?*

Yes No

If this individual practitioner **should be** affiliated will **ALL** locations under this tax ID, select yes. You will not need to submit multiple forms for each location. **Please note**, if there are 20 or more locations, we will contact you to confirm all locations before adding them to our systems.

If this individual practitioner has multiple locations, but **should not** be affiliated with all locations under this tax ID, select no. If no is selected here, you will have the option to add up to six additional locations later in this form.

Service Location Information

Service Location Information

Is the service location NPI the same as the billing NPI?*

Yes No

If the service location NPI is the same as the billing NPI, select "Yes."

Service Location Information

Is the service location NPI the same as the billing NPI?*

Yes No

Billing NPI*

If the service location NPI is different from the billing NPI, select "No." A new field will appear to enter the billing NPI.

Primary Service Location NPI*

Primary Service Location Name*

Service Location Address*
i.e. 123 Main St

Service Location City*

Service Location State*

Select... ▼

Service Location Zip Code*
5 or 9 digits only no dashes (-)

Service Location Primary Phone Number
Enter just the 10-digit number, no dashes or parenthesis. Example: 7207445500

Service Location Primary Fax Number
Enter just the 10-digit number, no dashes or parenthesis. Example: 7207445500

Please enter the NPI, name, address, and phone information for the primary service location for this individual practitioner.

Please ensure the service location NPI is validated with the state of Colorado. If the NPI is not validated, even though we have made the requested updates in our systems, the claims will be denied for non-validation.

Is the mailing address the same as the service location address?*

Yes

No

If the mailing address is the same as the service location address, select "Yes."

Is the mailing address the same as the service location address?*

Yes

No

Mailing Address*

City*

State*

Zipcode*

5 or 9 digits only no dashes (-)

If the mailing address is different from the main service location address, select “No.” New fields will appear to capture the mailing address information.

When affiliating to multiple but not ALL locations

Do you have additional Service Location NPIs for this provider?

Yes

No

If “No” was selected to affiliated with all locations, this option will show.
If “Yes” was selected to affiliate with all locations, this will not be on the form, and you can skip to the attaching documentation section.

To only affiliate with the main service location listed, select “No.”

Do you have additional Service Location NPIs for this provider?

Yes
 No

Please select how many additional service NPIs you need ⓘ
You can update this provider for up to six (6) additional service locations.

6 x

Additional Service Location NPI 1

Additional Service Location NPI 2

Additional Service Location NPI 3

Additional Service Location NPI 4

Additional Service Location NPI 5

Additional Service Location NPI 6

If yes is selected, you will have an option to pick how many additional locations are needed. There is a maximum of six additional locations. Enter each location’s specific NPI to affiliate this individual practitioner to.

Attaching Documentation

Do you have any supporting documentation? You can attach that here

Example: Professional Liability Insurance (PLI or COI), Medicaid Validation Approval Letter, additional service locations (7+), etc.

+

Drop files to attach or [browse](#)

Any supporting documentation can be attached here by either dragging and dropping the files to this box or by clicking browse to select the attachments.

Submit

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

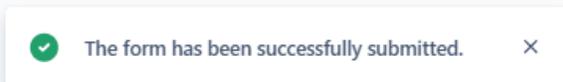
Thank you for using our new forms! Your request has been received

The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)



When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate. For example, if credentialing is required, the request will be shared with the credentialing team.

Please note, although the reference number shows the submission is completed, it does not mean that that credentialing has also been completed. If credentialing is required, a separate notification will be sent once credentialing is completed.

3. Clinical Staff Add Behavioral Health

The “Clinical Staff Add Behavioral Health” form is used to add individual practitioners to already contracted entities.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Main Office Information

Main Office Information

Office's Legal Name:*

Tax ID Number (SSN/EIN)*

No dashes, 9 digits only

Enter the main office legal name for this practitioner.

The tax ID entered should match the W-9 information used in the billing loop.

Provider Information

Provider Information

Provider NPI*

Provider First Name*

Provider MI

Provider Last Name*

Provider Date of Birth*

Please enter the providers date of birth mm/dd/yyyy

Gender

F M X Other

The provider information section collects the data for the individual practitioner that will be loaded into our systems.

The provider NPI that is entered must match the submitted provider name. If the NPI and name do not match according to the state validation report and/or NPPES, the request will be denied, and you will need to resubmit your request with the correct information.

Please also ensure the NPI is validated with the state of Colorado. If the NPI is not validated, even though we have made the requested updates in our systems, the claims will be denied for non-validation, and if required, credentialing will not be started.

Degree/Suffix*

i.e. MD, LPC, SLP, etc. Choose all that apply

CAQH# (please ensure profile is current)

<https://proview.caqh.org/Login?Type=PR>

Practicing Specialty

Select the "Degree/Suffix" from the drop-down menu.

If there is a CAQH number, please include that information. This will be used if credentialing is required. Please also indicate the practicing specialty, although not required.

Please indicate which specialty population you work with*

Children (12 and under) Adolescents (13-17) Adults (19 to 64) Seniors (65+) Foster care

Treatment: Children (12 and under)

Check the box to the left of the specialty population(s) this practitioner works with. A minimum of one is required, but multiple or all can be selected. If the field data is cut off, you can hover over the field to see the full field, as shown above.

Treatment Modalities

Aggression replac... Animal-assisted Art therapy Attachment-based...

Biofeedback Cognitive behavio... Dialectical behavi... Eye movement de...

Exposure and resp... Habit reversal ther... Multisystemic the... Psychological test...

Play therapy Sex offender man...

Check the box to the left of all the treatment modalities this practitioner works with.

Please check only the top ten specialties of your practice below*

<input type="checkbox"/> Adoption	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Alzheimer's/Deme...	<input type="checkbox"/> Anxiety/panic
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Autism Spectrum ...	<input type="checkbox"/> Bipolar Disorders	<input type="checkbox"/> Borderline Person...
<input type="checkbox"/> Brain Injury (TBI)	<input type="checkbox"/> Child Abuse	<input type="checkbox"/> Children of Alcoh...	<input type="checkbox"/> Chronic Pain or Ill...
<input type="checkbox"/> Compulsive Beha...	<input type="checkbox"/> Conduct Disorders	<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> Cultural Issues
<input type="checkbox"/> Depression	<input type="checkbox"/> Developmental Di...	<input type="checkbox"/> Disruptive Behavi...	<input type="checkbox"/> Dissociative Disor...
<input type="checkbox"/> Divorce/Custody	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Eating Disorders	<input type="checkbox"/> Elder Abuse
<input type="checkbox"/> End-of-Life	<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Gender Identity C...	<input type="checkbox"/> Grief and Loss
<input type="checkbox"/> Impulse Control	<input type="checkbox"/> Intellectual Disabi...	<input type="checkbox"/> Intimacy Issues	<input type="checkbox"/> LGBTQIA+ Coun...
<input type="checkbox"/> Learning Disabilities	<input type="checkbox"/> Life Transitions	<input type="checkbox"/> Men's Issues	<input type="checkbox"/> Mental Health Cer...
<input type="checkbox"/> Mood Disorders	<input type="checkbox"/> Neuropsychiatry	<input type="checkbox"/> Neuropsychology	<input type="checkbox"/> Obesity
<input type="checkbox"/> Obsessive Compu...	<input type="checkbox"/> Parenting Issues	<input type="checkbox"/> Personality Disord...	<input type="checkbox"/> Phobias
<input type="checkbox"/> Postpartum	<input type="checkbox"/> Post-Traumatic St...	<input type="checkbox"/> Psychological Illness	<input type="checkbox"/> Psychosis
<input type="checkbox"/> Psychosomatic Ill...	<input type="checkbox"/> Queer/Questioning	<input type="checkbox"/> Relationship Issues	<input type="checkbox"/> Relinquishment C...
<input type="checkbox"/> Reproductive	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Self-Harm/Self-In...	<input type="checkbox"/> Sexual Harassment
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/> Sexual Offenders	<input type="checkbox"/> Sleep/Insomnia	<input type="checkbox"/> Spiritual Concerns
<input type="checkbox"/> Stress Management	<input type="checkbox"/> Substance Use Dis...	<input type="checkbox"/> Trauma	<input type="checkbox"/> Violent Offenders
<input type="checkbox"/> Women's Issues			

Check the box to the left of the specialties this practitioner works with. A minimum of one is required, but up to 10 can be selected. Please do not select more than 10.

Effective Date of Change*

If date is unknown, select today's date

Feb 27, 2025

The effective date of change will default to today's date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Is provider practicing ONLY in an inpatient/hospitalist or locum tenens capacity?*

Select..

Use the drop-down menu to indicate if the individual practitioner is practicing ONLY in an inpatient/hospitalist or locum tenens capacity.

Affiliate provider with all locations NPIs under this tax ID?*

Yes No

If this individual practitioner **should be** affiliated will **ALL** locations under this tax ID, select yes. You will not need to submit multiple forms for each location. **Please note**, if there are 20 or more locations, we will contact you to confirm all locations before adding them to our systems.

If this individual practitioner has multiple locations, but **should not** be affiliated with all locations under this tax ID, select no. If no is selected here, you will have the option to add up to six additional locations later in this form.

Service Location Information

Service Location Information

Is the service location NPI the same as the billing NPI?*

Yes No

If the service location NPI is the same as the billing NPI, select "Yes."

Service Location Information

Is the service location NPI the same as the billing NPI?*

Yes No

Billing NPI*

If the service location NPI is different from the billing NPI, select "No." A new field will appear to enter the billing NPI.

Primary Service Location NPI*

Primary Service Location Name*

Service Location Address*
i.e. 123 Main St

Service Location City*

Service Location State*

Select... 

Service Location Zip Code*
5 or 9 digits only no dashes (-)

Service Location Primary Phone Number
Enter just the 10-digit number, no dashes or parenthesis. Example: 7207445500

Service Location Primary Fax Number
Enter just the 10-digit number, no dashes or parenthesis. Example: 7207445500

Please enter the NPI, name, address, and phone information for the primary service location for this individual practitioner.

Please ensure the service location NPI is validated with the state of Colorado. If the NPI is not validated, even though we have made the requested updates in our systems, the claims will be denied for non-validation.

Is the mailing address the same as the service location address?*

Yes

No

If the mailing address is the same as the service location address, select "Yes."

Is the mailing address the same as the service location address?*

Yes

No

Mailing Address*

City*

State*

Select... ▾

Zipcode*

5 or 9 digits only no dashes (-)

If the mailing address is different from the main service location address, select “No.” New fields will appear to capture the mailing address information.

When affiliating to multiple but not ALL locations

Do you have additional Service Location NPIs for this provider?

Yes

No

If “No” was selected to affiliate with all locations, this option will show. If “Yes” was selected to affiliate with all locations, this will not be on the form, and you can skip to the attaching documentation section.

To only affiliate with the main service location listed, select “No.”

Do you have additional Service Location NPIs for this provider?

Yes
 No

Please select how many additional service NPIs you need ⓘ
You can update this provider for up to six (6) additional service locations.

6 x

Additional Service Location NPI 1

Additional Service Location NPI 2

Additional Service Location NPI 3

Additional Service Location NPI 4

Additional Service Location NPI 5

Additional Service Location NPI 6

If “Yes” is selected, you will have an option to pick how many additional locations are needed. There is a maximum of six additional locations. Enter each location’s specific NPI to affiliate this individual practitioner to.

Attaching Documentation

Do you have any supporting documentation? You can attach that here

Example: Professional Liability Insurance (PLI or COI), Medicaid Validation Approval Letter, additional service locations (7+), etc.

+

Drop files to attach or [browse](#)

Any supporting documentation can be attached here by either dragging and dropping the files to this box or by clicking browse to select the attachments.

Submit

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

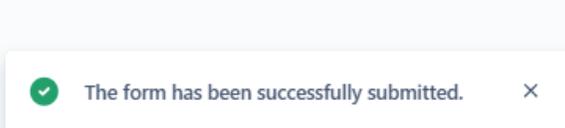
Thank you for using our new forms! Your request has been received

The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)



When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

Please note, although the reference number show the submission is completed, it does not mean that that credentialing has also been completed. If credentialing is required, a separate notification will be sent once credentialing is completed.

4. Clinical Staff Termination

The “Clinical Staff Termination” form is used to terminate individual practitioners from specific or all locations for contracted entities.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Main Office Information

Main Office Information

Office's Legal Name:*

Tax ID Number (SSN/EIN)*

No dashes, 9 digits only

Enter the main office legal name for this practitioner.

The tax ID entered should match the W-9 information used in the billing loop.

Provider Information

Provider Information

Provider NPI*

Provider First Name*

Provider MI

Provider Last Name*

The provider information section collects the data for the individual practitioner that will be terminated.

The provider NPI that is entered must match the submitted provider name. If the NPI and name do not match according to the state validation report and/or NPPES, the request will be denied, and you will need to resubmit your request with the correct information.

Effective Date of Change*

If date is unknown, select today's date

The effective date of change will default to today's date. Please update this date, if the effective date should be different than the date listed, and ensure the new date is saved when leaving that field.

Service Location Information

Service Location Information

Is provider being termed from all service location NPIs under this Tax ID?*

Yes

No

If this individual practitioner **should be** terminated from **ALL** locations under this tax ID, select "Yes." You will not need to submit multiple forms for each location.

If this individual practitioner has multiple locations, but **should not** be terminated with all locations under this tax ID, select "No." If "No" is selected here, you will have the option to add up to six additional locations.

Service Location Information

Is provider being termed from all service location NPIs under this Tax ID?*

Yes

No

Primary Service Location NPI*

If no is selected, a field to capture the primary service location NPI will appear. Please enter the primary service location NPI for the terminating practitioner.

Do you have additional Service Location NPIs for this provider?

Yes

No

If the only location to terminate this provider from is the main location, select "No." Otherwise, select "Yes."

Please select how many additional service NPIs you need ⓘ

You can update this provider for up to six (6) additional service locations.

6 x

Additional Service Location NPI 1

Additional Service Location NPI 2

Additional Service Location NPI 3

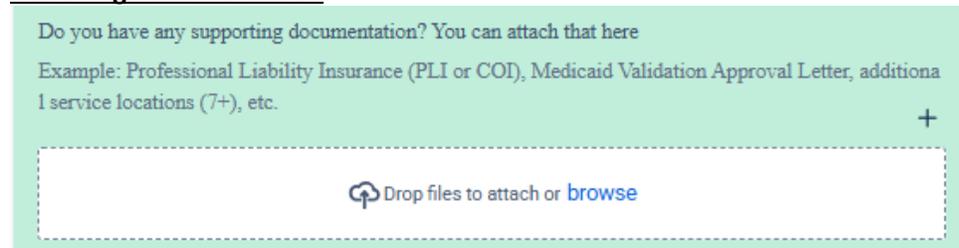
Additional Service Location NPI 4

Additional Service Location NPI 5

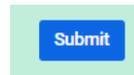
Additional Service Location NPI 6

If "Yes" is selected for additional locations, an option will appear to add up to six additional locations. Please include the specific NPIs for each additional location this practitioner should be terminated from.

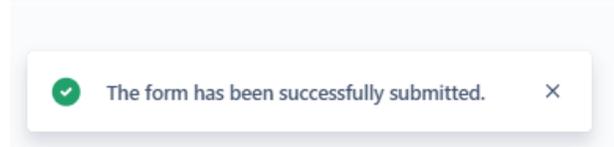
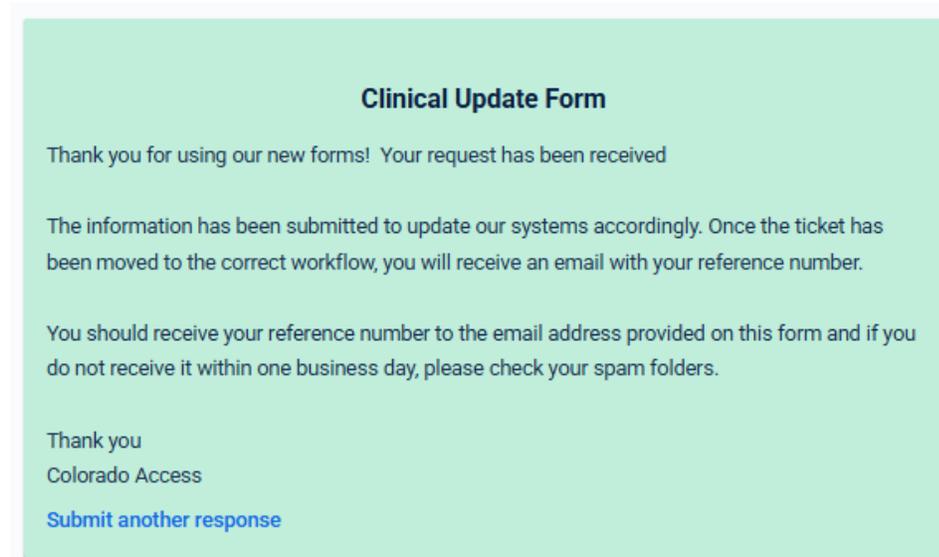
Attaching Documentation



Any supporting documentation can be attached here by either dragging and dropping the files to this box or by clicking browse to select the attachments.



Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.



When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

5. Clinic Closure

The “Clinic Closure” form is used to terminate a specific location for contracted entities.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Main Office Information

Main Office Information

Office's Legal Name:*

Tax ID Number (SSN/EIN)*

No dashes, 9 digits only

Enter the main office legal name for this practice.

The tax ID entered should match the W-9 information used in the billing loop.

Update Details

Update Details

Effective Date of Change*

If date is unknown, select today's date

The effective date of change will default to today’s date. Please update this date if the effective date should be different than the date listed and ensure the new date is saved when leaving that field.

Service Location Information

Service Location Information

Closing Location NPI*

Please provide the NPI of the location you are closing

Service Location Name*

Name of the closing location

Enter the unique NPI for the closing location.

Enter the name of the closing location.

Service Location Address*

i.e. 123 Main St

Service Location City*

Service Location State*

Select... ▼

Service Location Zip Code*

5 or 9 digits only no dashes (-)

Enter the address for the closing location.

We will term all providers affiliated with this service location NPI.*
Are they moving to a new service location?

Yes

i Please attach a list of provider names, their NPIs, the new service location's name, the new service location's NPI, and the effective date.

Note: providers must be moving to a service location with the same Tax ID number. If providers are moving to a new service location under a different Tax ID number, please reach out to contracting at provider.contracting@coaccess.com to determine if a new contract needs to be created.

Moving Providers List* +

Drop files to attach or [browse](#)

Use the drop-down to select if the providers affiliated with the closing location will be moving to a new service location. If “Yes” is selected, more information will appear to attach a list of the providers and which location(s) they are moving to.

Attaching Documentation

Do you have any supporting documentation? You can attach that here
Example: Professional Liability Insurance (PLI or COI), Medicaid Validation Approval Letter, additional service locations (7+), etc.

+
Drop files to attach or [browse](#)

Any supporting documentation can be attached here by either dragging and dropping the files to this box or by clicking browse to select the attachments.

Submit

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

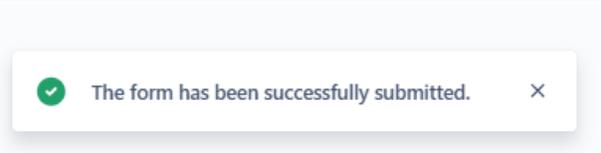
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You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)



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All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

6. Roster

The “Roster” form is used to terminate a specific location for contracted entities.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Main Office Information

Main Office Information

Office's Legal Name:*

Enter the main office legal name.

 Your roster attachment must include:

- Tax ID/EIN
- Provider First Name
- Provider Last Name
- Provider DOB
- Provider Gender (optional)
- Provider NPI
- Provider Degree
- Provider Location NPI
- Provider Location Effective Date
- Provider Location Address

Please note that the roster must contain, at minimum, the above information.

Attaching Roster

Attach the roster by either dragging and dropping the files to this box or by clicking browse to select the attachments.

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

Please note, although the reference number shows the submission is completed, it does not mean that that credentialing has also been completed. If credentialing is required, a separate notification will be sent once credentialing is completed.

7. Notification of Change



Clinical Update Form

Please complete this form to notify us of updates from your practice or organization.

With this form you can

- Add a provider
- Term a provider
- Make the following changes:
 - Tax-ID, NPI, Entity Name, Add a Clinic Address, Clinic Moved, Change an Address, etc.
- Clinic Closure
- Roster Upload

Fields with an asterisk (*) are required. The form may be denied if any required field is missing data.

Colorado Access does not discriminate or base credentialing decisions on an applicant's race, ethnicity, or language. Providing this information is optional.

Clinical Request Type*

Notification of Change
▼

What changes are you reporting?*

Select...
▼

Tax Identification Information (SSN/EIN)

NPI Number Information

Entity Name

Add A Clinic Address

Change an Address (Billing/Remit, Mailing, Physical)

Other

After selecting “What changes are you reporting?” an additional drop-down list will appear to specify what type of change to submit. If the change you need to submit is not listed, please select the “Other” option.

Please see the additional sections of this document that will provide a more detailed review of each of the “Notification of Change” forms.

8. Notification of Change – Tax identification Information (SSN/EIN)

The “Notification of Change” form for tax ID information is used to change an existing tax ID number.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

Office's Legal Name:*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Enter the office’s legal name for the entity with the TIN/SSN/EIN change.

Change Details

Effective Date of Change*

If date is unknown, select today's date

Feb 28, 2025

The effective date of change will default to today’s date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Current Tax Identification Number (SSN/EIN)*
Numbers only no dashes (-)

New Tax Identification Number (SSN/EIN)*
Numbers only no dashes (-)

Enter the current tax ID number that is changing.

Enter the new tax ID number. The tax ID entered should match the W-9 information that will be used in the billing loop.

If the tax ID AND name are changing, then our contracting team needs to be notified by email at provider.contracting@coaccess.com.

Reason For Change?*

Please enter a comment for the reason of the tax ID change.

Please attach W-9 with Tax ID information* +

 Drop files to attach or [browse](#)

A W-9 is required for all tax ID changes. Please attach it here by either dragging and dropping the files to this box or by clicking browse to select the attachments.

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

Thank you for using our new forms! Your request has been received

The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)

✓ The form has been successfully submitted. ✕

When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

9. Notification of Change – NPI Number Information

The “Notification of Change” form for NPI information is used to change an existing NPI number.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

Office's Legal Name:*

Tax ID Number (SSN/EIN)*
No dashes, 9 digits only

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Enter the office’s legal name for the entity/location with the NPI change.

Enter the tax ID of the entity.

Change Details

Effective Date of Change*

If date is unknown, select today's date

The effective date of change will default to today’s date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Current NPI*

New NPI*

Enter the current NPI that is changing.

Enter the new NPI. Please ensure the NPI is validated with the state of Colorado. If the NPI is not validated, even though we have made the requested updates in our systems, the claims will be denied for non-validation.

Reason For Change?*

Please enter a comment for the reason of the NPI change.

Submit

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

Thank you for using our new forms! Your request has been received

The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)

✓ The form has been successfully submitted. ✕

When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

10. Notification of Change – Entity Name

The “Notification of Change” form for entity name is used to change an existing entity legal and/or doing business as (DBA) name.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

Tax ID Number (SSN/EIN)*
No dashes, 9 digits only

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Enter the tax ID of the entity with the name change.

Change Details

Effective Date of Change*

If date is unknown, select today’s date

The effective date of change will default to today’s date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Prior Legal Name*

New Legal Name*

Enter the prior legal name.

Enter the new legal name.

If the tax ID AND name are changing, then our contracting team needs to be notified by email at provider.contracting@coaccess.com.

Are you changing the Doing Business As (DBA) name on file with us?

Yes
 No

Doing Business As (DBA) office name (if different than legal):*

If the name for the DBA is changing as well, select “Yes” and a new field will appear to capture the new DBA name. If “No” is selected, this field will not appear.

Does this change impact all NPIs for this TIN?

Yes
 No

If the change will impact all NPIs, select “Yes.” If it will not impact all NPIs for this TIN, select “No.”

Do you have additional Service Location NPIs for this provider?

Yes
 No

Please select how many additional service NPIs you need ⓘ
You can update this provider for up to six (6) additional service locations.

6 x

Additional Service Location NPI 1

Additional Service Location NPI 2

Additional Service Location NPI 3

Additional Service Location NPI 4

Additional Service Location NPI 5

Additional Service Location NPI 6

If “No” is selected to impact all NPIs for the TIN, the option for additional locations will not appear. If “Yes” is selected, an option to add up to six additional locations will appear. Please include all the unique location NPIs that are impacted.

Reason For Change?*

Please enter a comment for the reason of the entity name change.

Please attach W-9 with Tax ID information* +

Drop files to attach or [browse](#)

A W-9 is required for all name changes. Please attach it here by either dragging and dropping the files to this box or by clicking browse to select the attachments.

[Submit](#)

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

Thank you for using our new forms! Your request has been received

The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access
[Submit another response](#)

 The form has been successfully submitted. 

When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

11. Notification of Change – Add a Clinic Address

The “Notification of Change” form for adding a clinic address is used to add new locations.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Change Details

Effective Date of Change*

If date is unknown, select today’s date

The effective date of change will default to today’s date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Associate all active practitioners to this location?*

Yes
 No

Select “Yes” if all active practitioners under the tax ID should be affiliated with this new location. If you select “No,” please attach a list of the practitioners to affiliate at the end of the form.

Primary Service Location Name*

Service Location Address*

i.e. 123 Main St

Service Location City*

Service Location State*

Select... ▼

Service Location Zip Code*

5 or 9 digits only no dashes (-)

Enter the address information for the new location.

Service Location Primary Phone Number

Enter just the 10-digit number, no dashes or parenthesis. Example: 7207445500

Service Location Primary Fax Number

Enter just the 10-digit number, no dashes or parenthesis. Example: 7207445500

Enter the phone numbers for the new location.

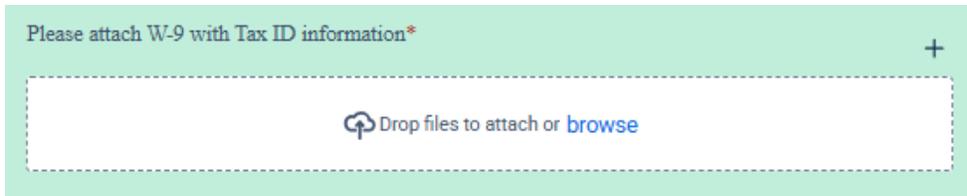
Current Tax Identification Number (SSN/EIN)*

Numbers only no dashes (-)

New NPI*

Enter the current tax ID for the entity. The tax ID entered should match the W-9 information used in the billing loop.

Enter the new NPI for the new location. Please ensure the NPI is validated with the state of Colorado. If the NPI is not validated, even though we have made the requested updates in our systems, the claims will be denied for non-validation.

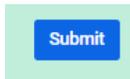


Please attach W-9 with Tax ID information*

Drop files to attach or [browse](#)

A dashed rectangular box with a light green border and a plus sign in the top right corner. Inside the box, there is a blue icon of a document with a plus sign and the text "Drop files to attach or browse".

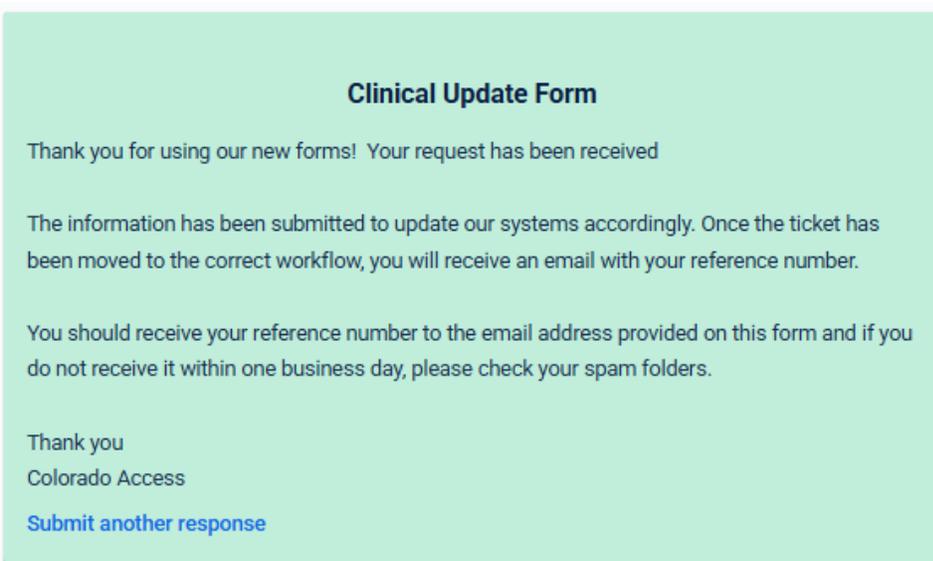
A W-9 is required for new addresses. Please attach it here by either dragging and dropping the files to this box or by clicking browse to select the attachments.



Submit

A blue rectangular button with the word "Submit" in white text.

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.



Clinical Update Form

Thank you for using our new forms! Your request has been received

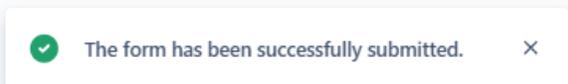
The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)

A light green rectangular box containing the following text and a link.



✓ The form has been successfully submitted. ✕

A white notification box with a green checkmark icon on the left and a close button (✕) on the right.

When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

12. Notification of Change – Change an Address (Billing/Remit, Mailing, Physical)

The “Notification of Change” form for changing an address is used to submit address changes to either billing/remit, mailing, and/or physical addresses.

All fields with an * are required and the form cannot be submitted until it is populated.

What address(es) are we changing?*

Select one or more

Physical Address - Clinic Moved

Mailing Address

Billing/Remit Address

Check the addresses that need a change. A minimum of one is required but all can be selected if applicable.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Main Office Information

Main Office Information

Office's Legal Name:*

Tax ID Number (SSN/EIN)*

No dashes, 9 digits only

Enter the main office legal name.

The tax ID entered should match the W-9 information used in the billing loop.

Change Details

Change Details

Effective Date of Change*

If date is unknown, select today's date

Feb 28, 2025 ✕

The effective date of change will default to today's date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Current NPI*

Enter the current NPI for the physical address.

Physical Address - Clinic Moved*

Please enter the complete new physical address for the clinic e.g. 123 Main St Aurora CO 80013

EXAMPLE: 123 Main St Aurora CO 80013

Billing/Remit Address*

Please enter the complete new Remit address for the clinic e.g. 123 Main St Aurora CO 80013

EXAMPLE: 123 Main St Aurora CO 80013

Mailing Address*

Please enter the complete new billing address e.g. 123 Main St Aurora CO 80013

EXAMPLE: 123 Main St Aurora CO 80013

Enter the new address(s) as applicable. Some fields may not appear if the type of change wasn't selected above.

Reason For Change?*

Please enter a comment for the address change(s).

Please attach W-9 with Tax ID information* +



A W-9 is required for new billing/remit addresses. Please attach it here by either dragging and dropping the files to this box or by clicking browse to select the attachments. This option will not appear if billing/remit was not selected.

A blue rectangular button with the word "Submit" in white text.

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

Thank you for using our new forms! Your request has been received

The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)



The form has been successfully submitted.



When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form** and will include a reference number.

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.

13. Notification of Change - Other

The “Notification of Change” form for all other requests is used to submit changes that are not captured in any of the other forms.

All fields with an * are required and the form cannot be submitted until it is populated.

Submitter Information

Submitter Information

Office Contact Name

Office Contact Email*

It’s important to accurately enter the office contact email. We will use this email if we have any questions or need more information to complete the request. If a response is not received within five days of our outreach, the ticket will be closed, and you will need to resubmit your request.

Main Office Information

Main Office Information

Office's Legal Name:*

Tax ID Number (SSN/EIN)*

No dashes, 9 digits only

Enter the main office legal name.

The tax ID entered should match the W-9 information used in the billing loop.

Effective Date of Change*

If date is unknown, select today's date

The effective date of change will default to today’s date. If the effective date should be different than the date listed, please update this date and ensure the new date is saved when leaving that field.

Attaching Documentation

Do you have any supporting documentation? You can attach that here

Example: Professional Liability Insurance (PLI or COI), Medicaid Validation Approval Letter, additional service locations (7+), etc.

+

 Drop files to attach or [browse](#)

Any supporting documentation can be attached here by either dragging and dropping the files to this box or by clicking browse to select the attachments.

Comments*

Please include a detailed description of what change(s) are needed with this request.

[Submit](#)

Once the form is complete, click the submit button. If there is required information that is missing or not correctly formatted, the form will not be submitted, and an indicator will show what still needs to be completed.

Clinical Update Form

Thank you for using our new forms! Your request has been received

The information has been submitted to update our systems accordingly. Once the ticket has been moved to the correct workflow, you will receive an email with your reference number.

You should receive your reference number to the email address provided on this form and if you do not receive it within one business day, please check your spam folders.

Thank you
Colorado Access

[Submit another response](#)

✔The form has been successfully submitted.✕

When the form is successfully submitted, this new screen will show it's been submitted.

All forms submitted will receive a confirmation email to the **office contact email submitted on the form and will include a reference number.**

When the request is completed by the configuration team, a completion email will be sent to the office contact email submitted on the form and will also include the reference number. These requests will be shared with other teams at Colorado Access, as appropriate.