COLORADO ACCESS PROVIDER-CARRIER DISPUTE FORM

All fields are required. If information is missing, the appeal will not be processed and will be returned to the address listed on the form below.

- ☐ CHP+ offered by Colorado Access
- ☐ ACCBDH (Behavioral Health Denver Health)
- ☐ ACCB3 (Behavioral Health Region 3)
- ☐ ACCB5 (Behavioral Health Region 5)

COMPLETE A SEPARATE REQUEST FOR EACH RECIPIENT AND/OR CLAIM. *INCLUDE THE FOLLOWING:*

1. A copy of the claim in question
2. A copy of the EOP showing the recent payment
3. Medicare/Third Party Liability - a copy of the Explanation of Benefits
4. Other documentation as necessary*

**If you are making this appeal on the member's behalf, please visit coaccess.com/members/services/appeals, and/or the "Appeals" section in the Health First Colorado Member Handbook on the Health First Colorado website for a separate process. To submit an appeal on a member's behalf, you will need to provide us with permission (as the Designated Client Representative) from the member and follow the member appeal process instead of the Provider-Carrier Dispute process.*

Provider Name:		
Billing Address:		
City:	State:	Zip:
Contact Name:	Phone:	
Email Address:		

ALL FIELDS BELOW MUST BE COMPLETED

State Medicaid ID:	Date of Service:	
Member Name:	EOP Date:	Paid Amount:
Billing Provider TIN:	Claim Number:	
Billing Provider NPI:	Rendering Provider NPI:	

DESCRIBE REQUEST (YOUR DESCRIPTION MUST INCLUDE ANY PROCEDURE CODES/UNITS/AMOUNTS, ETC.)

Date: By (Provider Authorized Signature):

Send request with all necessary information to:	Provider Portal: bit.ly/46oQJbb	Email: claimappeals@coaccess.com	Mail: Provider-Carrier Disputes PO Box 17189 Denver, CO 80217