# 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.

☐ Child Health Plan *Plus* (CHP+)offered by Colorado Access

☐ ACCBDH (Behavioral health Denver Health)

☐ ACCB3 (Behavioral health Region 3)

☐ ACCB4 (Behavioral health Region 4)

☐ 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 Explanation of Payment (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 read the "Appeals" section in the Health First Colorado Member Handbook on the Health First Colorado (Colorado's Medicaid program) 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: | |

Email address:

**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