Dear Provider:

Thank you for your interest in becoming a Rocky Mountain Health Plans (RMHP) participating provider. To avoid delays in processing your request, please complete the attached Credentialing Data Form, and be sure to include/complete the following:

- Current W-9.
- For your credentialing, RMHP will utilize the Council for Affordable Quality Healthcare (CAQH) online application, located at https://proview.caqh.org/.
  - Be sure that RMHP is authorized to view your application.
  - Verify that the professional claims history in the disclosure section accurately reflects your complete claims history (settled, dismissed, etc.).
  - Please verify that the CAQH application is filled out completely with no missing information.
- Please provide an accurate email address for the person who handles credentialing for you, as RMHP staff will send credentialing updates via email.

The credentialing process will not begin until your CAQH application is complete. Any missing or incomplete documentation will also delay the initiation of the credentialing process.

Thank you for your diligence in ensuring your file is complete during this process.

Sincerely,

RMHP Provider Relations Team
Rocky Mountain Health Plans

Today's Date: ______________________________

Is the provider hospital based or a physician assistant? ☐ Yes ☐ No

If so, please list the effective date:

CREDENTIALING DATA FORM					
Last Name:		First Name:		MI:	Title (i.e. MD):
Credentialing Contact Name:				Phone:	
Credentialing Contact Email (**Required**):					
Credentialing Contact Address:					
CAQH ID:		Are you a primary care physician (PCP)? ☐ Yes ☐ No			
Provider's Degree (i.e. BA, MA, etc.):		Specialty:		CO License #:	
DOB:	SSN:	DEA#:	Provider NPI:		
Supervising Physician (if a physician assistant):					
Is the provider enrolled in the interchange as a participating provider through Health First Colorado (Colorado's Medicaid Program)? ☐ Yes ☐ No State Location ID#: Date application approved:					
GROUP / PRACTICE INFORMATION					
Group Name:			Tax ID:		
Office Manager's Name:					
Office Manager's Email (**Required**):					
Primary Practice Address:			City:		
State:	Zip:	Phone:	Fax:		
Mailing Address:			City:		
State:	Zip:	Phone:	Fax:		
Billing (Remit) Address:			City:		
State:	Zip:	Phone:	Fax:		
ADDITIONAL PRACTICE ADDRESSES					
Please attach additional practice addresses on a separate sheet.					

Please fax the completed form to RMHP Provider Relations at 970-244-7957