COLORADO
Department of Health Care Policy & Financing

# Load Letter Request & Late Bill Override Date Request Form (LLR / LBOD)

**DO NOT ALTER THIS FORM**

The Department will accept requests on this form only. Your request will be processed within 10 business days. NOTE: Please write legibly. Forms missing information will be sent back to the requestor which will cause a delay in the request. If you have any questions, please email: loadletterrequests@hcpf.state.co.us.

Note: If the dates of service are within 365 days from the date of the request you will not be issued a LL, instead you will be advised to use the Late Bill Override Date Process (LBOD). Please refer to the LBOD instructions located in the Provider Services Billing Manuals section of the Department's Web site.

Today's Date: _____

**Client Information:**

State Medicaid ID: _____ DOB: _____ SSN: _____

Last Name: _____ First Name: _____

Dates of Service to be covered with the Request: _____

*(*For Department Use Only: Please leave this section blank)*

**County of Residence*_____

**Medicaid Verification of Eligibility Date*_____**Case number*_____

**Return Completed Load Letter to:**

Provider Name: _____Provider Medicaid ID: _____

Name of Contact: _____ E-mail_____

Phone Number: _____FAX NUMBER:_____

DO NOT Check this box ☐ **unless** you represent a Behavioral Health Organization (BHO).

Send completed from by **ENCRYPTED** Email to: loadletterrequests@hcpf.state.co.us
If you are unable to encrypt the form, you may also fax your request to: **303-866-2082** (no cover sheet needed)

If there is a reason ***beyond your control*** that caused you to bill this claim beyond the 120 days timely billing cycle please write a brief explanation below.