

The NHP Care Coordination Referral Form will go live on 7/1/2025

Please use when referring Health First Colorado (Colorado's Medicaid Program) members for care coordination services.

Referring From	Member Information	Alternate Contact	Reason for Referral	Review	Submit
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Referring Agency/Practice *

Person Referring *

Referral Date *

M/D/YYYY

Email *

Phone *


Provide a telephone number

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Member Name *



Member DOB *




Member Phone *




Health First Colorado ID # *

Member Address *



Attribution Region *



Primary Language *

PCMP *

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Alternate Contact Name

Alternate Contact Phone

Provide a telephone number

Relationship to Member

Member has consented to contact and exchange information with this person

☒ No ☐ Yes

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Reason for Referral *

Select or search options

If other, please specify

If EPSDT was selected

Select or search options

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