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**Colorado Medicaid**  
**Department of Healthcare Policy and Financing**  
Please give me a copy of your insurance card (if applicable)

State ID: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Name of Person Completing This Form

\_\_\_\_\_  
Relationship to Patient