PLEASE DO NOT DOUBLE-SIDE or DUPLEX

Instructions for Completing Address Changes

Please use the fillable feature of the .pdf document or print legibly.

*** Please note that the new HIPAA format requires the use of 9-digit zip codes on all CBO Forms***

The EI Service Matrix:

Provider Connections sends this page to the Central Billing Office along with the W-9 Form. Please include appropriate documentation of the name change, such as a marriage certificate, portion of a divorce decree allowing the use of a previous name, or other legal document.

- List your name as you want it for billing purposes. Fields are available for first, middle, and last names.
- Enter your home address.
- Enter your Social Security Number.
- Indicate your personal National Provider Identification (NPI) number. This does not apply to Parent Liaisons, Service Coordinators, Interpreters, and Translators. **Applications missing the NPI number cannot be processed.** You can obtain one by going to https://nppes.cms.hhs.gov.
- List your current e-mail address. Since some providers have more than one employer, an individual e-mail address is preferred.
- List the county or counties you will serve.
- "Payee Name" refers to the individual provider's name or the agency name that is being used to receive payment.
- Enter the Payee Tax Identification Number. This would be your SSN if an individual or the Tax Identification Number of the payee.
- Enter the CFC(s) you will serve.
- Enter the Payee Site Address.
- Enter the Payee Billing Address if different from the Payee Site Address.
- List the Payee Phone and Fax numbers.
- Indicate each type of early intervention service you provide directly with a ✓.
- Check the appropriate box for IMPACT Validation/Enrollment and list your IMPACT Application ID.
- Sign and date the form.

If you are an agency that is changing its name or address, one Service Matrix may be completed for one employee. Attach a listing of current employees with the documents.

Do Not Email Due to Sensitive Information

EI Service Matrix

Individual Provider Name _____
First Middle Last

Home Address _____
(Street, City, State, Zip+4 Code)

Individual Phone Number _____ Individual SSN _____ Individual NPI # _____
National Provider ID

Email _____ County/Counties Served _____

Payee Name _____

Payee Tax Identification Number _____ CFCs Served _____

Payee Site Address _____
(Street, City, State, Zip+4 Code)

Payee Billing Address _____

Payee Phone Number _____ Fax Number _____

If you have been previously enrolled with Provider Connections, please list the name you used: _____

Early Intervention Services

- ☐ Assistive Technology
- ☐ Audiology
- ☐ Aural Rehabilitation
- ☐ Developmental Evaluation (physicians only)
- ☐ Nursing
- ☐ Nutrition
- ☐ Consultation (physicians only)
- ☐ Licensed Occupational Therapist
- ☐ Licensed Physical Therapist
- ☐ Board Certified Behavior Analyst
- ☐ Licensed Professional Counselor
- ☐ Licensed Clinical Professional Counselor
- ☐ Transportation
  - ☐ Parent Transportation Provider
- ☐ Licensed Clinical Psychologist
- ☐ Licensed Social Worker
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Marriage/Family Therapist
- ☐ Licensed Regional Optometrist
- ☐ Developmental Therapist ☐ Hearing ☐ Vision ☐ O & M
- ☐ Service Coordinator (list CFC #) _____
- ☐ Licensed Speech/Language Pathologist
- ☐ Deaf Interpreter **(certification and SO Training required)**
- ☐ Bi-Lingual Interpreter **(Proficiency Test & SO for Bilingual Interpreter required)**
  _____ **(Language)**
  - ☐ **Writing Proficient (Proficiency Exam Required)**
  - ☐ **Speaking Proficient (Proficiency Exam Required)**

Are you enrolled/validated with the IMPACT system? Yes ☐ No ☐

IMPACT Application ID _____

_____ _____
Signature (Required) Date