

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.

- 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.
- 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 _____ SSN _____ Individual NPI # _____
National Provider ID

Email (required) _____ County/Countries Served _____

Payee Name _____

Payee Tax Identification Number _____ CFCs Served _____

Payee Site Address _____
Street City State Zip+4 Code

Payee Billing Address _____
Street City State Zip+4 Code

Payee Phone Number _____ Fax Number _____

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

Early Intervention Services

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

Are you enrolled/validated in the IMPACT System? Yes No

_____ Signature (Required)	_____ Date
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