**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/Counties 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

☐ Assistive Technology
☐ Audiology
☐ Aural Rehabilitation
☐ Developmental Evaluation (physicians only)
☐ Nursing
☐ Nutrition
☐ Consultation (physicians only)
☐ Licensed Occupational Therapist
☐ Licensed Physical Therapist
☐ Board Certified Behavioral 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)
☐ Parent Liaison (list CFC #) ____________
☐ Bi-Lingual Interpreter (Proficiency Test & SO for Bi-Lingual Interpreter required)
  ____________ (Language)
  ☐ Writing Proficient (Proficiency Exam Required)
  ☐ Speaking Proficient (Proficiency Exam Required)

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

| Signature (Required) | Date |
|---|---|
| ____________________ | ____________ |

R09/2023