**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.
- 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: _____

Type of Visit ☐ In-Person ☐ LVV ☐ Both

### 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

R02/25