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