CFO PROVIDER ENROLLMENT

Attn: Provider Enrollment
CSC Covansys
P. O. Box 29134
Shawnee Mission KS 66201- 9134

CFO Use Only
Date Received:
Part C Number:

Provider Enrollment 866-305-4985Option 2 **Fax: 913.888.6683** **http://la.eikids.com** **Email: laeienroll@csc.com**

Provider Information

Please complete this form using the organization information or your information if you are an Independent provider. If you are currently enrolled, please provide the information currently in the CFO system. Send completed form to the address at the top.

Payee Federal Tax Id Number:______________________ Payee/Facility Name:______________________

First Name:____________ M:____ Last Name:____________________ Email:______________

Site Address(services are performed here)______________________________

City:______________________ State__________ Zip:__________

Phone: ( ) - EXT: Fax: ( ) -

Name Of Primary Contact for Enrollment Questions:

Billing Information

- ❑ **New Information**
- ❑ **Change of Information**

Please indicate the type of change: ___Specialty ___Name ___Phone ___Fax ____Address ____Site ___Billing

___ Dis-Enrolling: Last Date Of Work______/_____/______ ___Re-Enrollment Facility ___Re-Enrollment Independent

Payee/Facility Name:______________________________

ProviderName:______________________ Specialty Level (Circle One): Associate or Specialist

Billing Address:______________________________

City:______________________ State:__________ ZIP:__________

Phone: ( ) - EXT: Fax: ( ) -

Early Intervention Discipline

Please select one of the following service types indicating the designation for your enrollment.

____ Audiologist
____ Assistive Technology Provider
____ Behavioral Consultant
____ Counselor
____ Dietitian (Registered)
____ Family Specialist
____ Family Service Coordinator
____ Foreign Language Translator
____ Interpreter for the Deaf
____ Nurse (Registered)
____ Nurse (Licensed Practical Nurse)
____ Nutritionist
____ Occupational Therapy Assistant (COTA) Certified
____ Occupational Therapist
____ Optometrist
____ Orientation/Mobility Specialist
____ Parent Educator
____ Parent Advisor for Children with Sensory Impairments
____ Physical Therapist
____ Physical Therapy Assistant (PTA)
___ Physician
___ Psychologist
___ School Psychologist
___ Social Worker
___ Special Instructor LEA
___ Special Instructor
___ Special Instructor Assistant
___ Speech Pathologist
___ Speech Pathologist Associate
___ Transportation Provider
____ Other (Please Specify) ______________________________

Please be aware that you may not provide services until you are listed as a provider at your local System Point Of Entry (SPOE). Provider status will be updated upon the receipt of completed agreements. The date the information is received at the CFO office will determine the effective date of your provider status.

Signature:______________________________ Date ______________