



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

Provider Enrollment 866-711-2573 Option 2

Fax: 913.888.6683 <http://missouri.eikids.com>
www.mofirststeps.com

Email: mofsenroll@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: _____

Provider Name: _____ Specialty Level (Circle One): Associate or Specialist

Billing Address: _____

City: _____ State: _____ ZIP: _____

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

Are you currently enrolled by the First Steps system as an Early Intervention practitioner? ___ No ___ Yes

If yes, how are you currently enrolled? ___ Independently ___ With a Facility ___ Both

Early Intervention Discipline Please select one of the following specialties indicating the designation for your enrollment.

<input type="checkbox"/>	ABA Provider	<input type="checkbox"/>	Nurse (Registered)	<input type="checkbox"/>	Physical Therapy Assistant (PTA)
<input type="checkbox"/>	ABA Implementer	<input type="checkbox"/>	Occupational Therapy Assistant (COTA) Certified	<input type="checkbox"/>	Physician
<input type="checkbox"/>	Assistive Technology Provider	<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/>	Psychologist
<input type="checkbox"/>	Audiologist	<input type="checkbox"/>	Optometrist	<input type="checkbox"/>	Service Coordinator
<input type="checkbox"/>	Counselor	<input type="checkbox"/>	Ophthalmologist	<input type="checkbox"/>	Social Worker
<input type="checkbox"/>	Dietitian	<input type="checkbox"/>	Orientation/Mobility Specialist	<input type="checkbox"/>	Special Instructor/Developmental Spec
<input type="checkbox"/>	Foreign Language Translator	<input type="checkbox"/>	Para Professional In Early Intervention	<input type="checkbox"/>	Special Instructor - Hearing Impairment
<input type="checkbox"/>	Intake Coordinator	<input type="checkbox"/>	Parent Advisor for Hearing Impairments	<input type="checkbox"/>	Special Instructor - Vision Impairment
<input type="checkbox"/>	Interpreters for the Deaf	<input type="checkbox"/>	Parent Advisor for Visual Impairments	<input type="checkbox"/>	Speech Pathologist
<input type="checkbox"/>	Nurse (Licensed Practical Nurse)	<input type="checkbox"/>	Physical Therapist	<input type="checkbox"/>	Transportation Provider
<input type="checkbox"/>	Other (Please Specify) _____	<input type="checkbox"/>		<input type="checkbox"/>	Family Member

Please be aware that you may not provide services until you are listed as a provider on the Service Matrix (<http://missouri.eikids.com>).

If you are requesting a change in status (i.e. from associate to specialist level) that requires supporting documentation (Degree, License, etc), please attach the documentation to this form. If you are requesting a change in payee name or individual name please complete a W-9 form available on the website and submit it to our office with this form. 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 _____