



CRO PROVIDER ENROLLMENT
Attn: Indiana Provider Enrollment
CSC Covansys
P. O. Box 29160
Shawnee Mission KS 66201- 9160

Provider Enrollment 866.339.9595 Option 2 Fax: 913.888.6683 www.infirststeps.com Email: infsenroll@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 CRO system. Send completed form to the address at the top.

Payee Federal Tax ID/Social Security Number: _____ Payee/Facility Name: _____

First Name: _____ M: _____ Last Name: _____ Member NPI: _____

Site Address (services are performed here) _____ City: _____

State: _____ Zip: _____ Email: _____

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: _____ Group NPI: _____

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

Provider Matrix Information

Name on License: _____ Professional License Type: _____

License #: _____ State: _____ Expiration Date: _____ Name on Degree: _____

Degree Type: _____ Description of Degree: _____ Institution: _____



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

<input type="checkbox"/>	Audiologist	<input type="checkbox"/>	Interpreter – Associate	<input type="checkbox"/>	Otologist/Laryngologist/Rhinol
<input type="checkbox"/>	Clinical Social Worker	<input type="checkbox"/>	Interpreter - Specialist	<input type="checkbox"/>	Pediatric Nurse Practitioner
<input type="checkbox"/>	Common Carrier (Non-Ambulatory)	<input type="checkbox"/>	LPN (Licensed Practical Nurse)	<input type="checkbox"/>	Pediatrician
<input type="checkbox"/>	Developmental/Education Specialist	<input type="checkbox"/>	Marriage and Family Therapist	<input type="checkbox"/>	Physical Therapist
<input type="checkbox"/>	Developmental/Education Spec – Behavioral Specialist	<input type="checkbox"/>	MSW (Certified Clinical Social Worker)	<input type="checkbox"/>	Physical Therapist Assistant
<input type="checkbox"/>	Developmental/Education Spec – Communication Specialist	<input type="checkbox"/>	Neonatologist	<input type="checkbox"/>	Psychiatrist
<input type="checkbox"/>	Developmental/Education Spec – Hearing Impaired	<input type="checkbox"/>	Neurologist	<input type="checkbox"/>	Psychologist
<input type="checkbox"/>	Developmental/Education Spec –Vision Impaired	<input type="checkbox"/>	Nurse Practitioner	<input type="checkbox"/>	Registered Dietician
<input type="checkbox"/>	DME/Medical Supply Dealer/Assist Tech	<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/>	RN (Registered Nurse)
<input type="checkbox"/>	Family Member-Transportation	<input type="checkbox"/>	Occupational Therapy Assistant	<input type="checkbox"/>	Service Coordinator
<input type="checkbox"/>	General Internist with sub-specialty	<input type="checkbox"/>	Ophthalmologist	<input type="checkbox"/>	Speech Pathologist
<input type="checkbox"/>	General Internist without sub-specialty	<input type="checkbox"/>	Optometrist	<input type="checkbox"/>	Speech Pathologist/Audiologist Aide
<input type="checkbox"/>	General Practitioner	<input type="checkbox"/>	Orientation/Mobility Specialist	<input type="checkbox"/>	Vision Specialist
<input type="checkbox"/>	Hearing Aid Dealer	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Other (Please Specify) _____	<input type="checkbox"/>		<input type="checkbox"/>	

Please be aware that you may not provide services until you are listed as a provider on the Service Matrix (<http://www.infirststeps.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 CRO office will determine the effective date of your provider status.

Signature: _____ Date _____