

Practitioner Information

Please complete this form using the organization information.

If you are currently enrolled, please provide the information currently in the CMO system. Send completed form to the address at the top.

Payee/Agency Federal Tax Id Number: _____ Payee/Agency Name: _____

First Name: _____ M: _____ Last Name: _____ Email: _____

Site Address(Agency location where you report) _____

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 Practitioner

Payee/Agency Name: _____

Practitioner Name: _____ Are you an Associate? Yes _____

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.

- | | | |
|------------------------------------|---------------------------------------|---|
| _____ Assistive Technology Vendor | _____ Nutritionist | _____ Social Worker |
| _____ Audiologist | _____ Occupational Ther Asst COTA | _____ Special Educator |
| _____ Behavior Specialist | _____ Occupational Therapist | _____ Special Educator-Visually Impaired |
| _____ Child Development Specialist | _____ Orientation/Mobility Specialist | _____ Special Educator-Hearing Impaired |
| _____ Child Development Associate | _____ Physical Therapist | _____ Speech/Language Pathologist |
| _____ Family Therapist | _____ Physical Therapist Asst PTA | _____ Transportation Vendor |
| _____ Family Member Transportation | _____ Pediatrician | _____ Service Coordinator Assoc |
| _____ Foreign Language Translator | _____ Physician | _____ Service Coordinator (indicate discipline of specialization below. Required) |
| _____ Hearing Aid Dispenser | _____ Ophthalmologist | _____ |
| _____ Interpreter for the Deaf | _____ Optometrist | _____ License Number (if applicable) |
| _____ Nurse (Registered) | _____ Psychologist | _____ |

If you are requesting a change in status that requires supporting documentation (Degree, License, etc), please attach the documentation to this form. If you are requesting a change in payee name or practitioner name please complete a W-9 form available on the website and submit it to our office with this form. Practitioner status will be updated upon the receipt of completed agreements. The date the information is received at the CMO office will determine the effective date of your practitioner status.

Signature/Date: _____ Date _____

Authorized Agency Official Signature/Date _____ Date _____

Authorized Agency Official Printed Name _____