WEST CENTRAL EARLY STEPS PROVIDER ENROLLMENT APPLICATION

Agency Name: _____

Doing Business As: _____

Physical Address: _____

City: _____ **State:** _____ **Zip Code (with ext):** _____

Mailing Address (if different than physical address): _____

City: _____ **State:** _____ **Zip Code (with ext):** _____

Phone Number: (_____**)** _____ **Extension:**_____ **FAX Number:** _____

Cell Phone number: (_____**)**_____ **E-Mail:**_____

Tax ID:_____ **NPI Group Number** _____ **Medicaid Group Number(s):** _____

Administrative Contact: _____ **Fiscal Contact:** _____ **Service Contact:**_____

Date Liability Insurance Expires: _____

Provider Name: _____ **Title:** _____

Completed CMS/ES Orientation Training Modules 1, 2, and 3 (Dates): _____

Social Security Number: _____ **NPI Number:** _____

Individual Medicaid Provider Number: _____ **Date Eligible To Bill Medicaid:** _____

Individual EI Medicaid Number: _____ **Date Eligible to bill Medicaid:** _____

License Number: _____ **License Expiration:** _____ **Liability Insurance Expires:** _____

Area of Specialty (e.g., feeding, sensory integration, autism): _____

Languages Spoken

Counties Served

	Citrus		**Hernando**		**Pasco**		**Pinellas**

BDI-2 Training **Yes** _____ **No** _____ **(If you have training, please provider documentation)**

For Early Steps Use Only: Date Application Received: _____ Agency Code: _____ Provide Code: _____