RESET

Indiana First Steps
Annual Update Form for Exempt Providers

Name:

Exempt providers are independent providers who are exempt from First Steps credentialing requirements. This includes audiologists, interpreters, orientation/mobility specialists, physicians, registered nurses, and vision specialists (ophthalmologists and optometrists).

This form and any required supporting documentation must be emailed to Public Consulting Group (PCG) Provider Enrollment Management (PEM) Team at:
Email: ineihubenroll@pcgus.com | Phone: 877-522-1065

Annual update checklist

- ☐ Annual update form with signed attestation statement (page 2)
- ☐ Signed agreement with the Division of Disability and Rehabilitative Services
- ☐ Limited criminal history check from Indiana State Police (12 months current)
- ☐ National Provider Identifier (NPI) (required for all providers)
- ☐ Copy of license (licensed providers only)
- ☐ Liability insurance certificate (if applicable)

Discipline

☐ Audiologist	☐ Interpreter	☐ Orientation/Mobility Specialist
☐ Physician	☐ Registered Nurse	☐ Vision Specialist (optometry & ophthalmology)
☐ Other (write in)		

Prior Convictions

Have you ever been convicted* of a crime other than a minor traffic violation?

◯ Yes ◯ No

*Convicted means you were declared guilty by a judge or you pleaded guilty in a court of law.
Answering yes to this question does not automatically disqualify an individual from working in First Steps.

Personnel Information

☐ Current information ☐ Change of information

Name

Email address

Previous name (if name change)

Phone

Discipline: Select one...

Second discipline*: Select one...

Professional license type*

License number*

License expiration*

Liability insurance agency*

Ins. policy number*

Ins. expiration*

Current criminal history inquiry date

NPI number

*If applicable

Billing Information

Required if billing information is different from Personnel Information above.

☐ Current information ☐ Change of information

Payee name

Payee billing address

Payee phone

Payee fax*

Group NPI number*

*If applicable

Attestation Statement: I hereby swear or affirm under penalty of disenrollment from First Steps that I understand and meet the requirements for providing First Steps services and that the information I am submitting is true and correct to the best of my knowledge.

Name (please print)_____

Signature_____ Date_____