



Central Reimbursement Office
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

**DME/Assistive Technology or Interpreter
Enrollment Checklist**

1. Name: _____
2. () CRO Provider Enrollment form
3. () Central Reimbursement office (CRO) Provider Agreement
4. () IRS Form W-9
5. () E-mail Address
6. () Electronic Funds Transfer Form (EFT) and voided or cancelled check
7. () Rider A
8. () Liability Insurance Certificate (DME/Assistive Technology)
9. () Online Access form
10. () IHCP Provider Enrollment Application Packet (Medicaid/Private Insurance Providers)
www.indianamedicaid.com Select: Provider Services

Signature: _____ Date: _____
Person completing this checklist

Mail all checked items along with this cover sheet to the address below. We cannot accept photocopies of signed documents or signed documents via fax. Documents with original signatures must be submitted. Please submit to:

Indiana First Steps Provider Enrollment
C/o CSC Covansys
P. O. Box 29160
Shawnee Mission, KS 66201-9160
Telephone: 1-866-339-9595 Option 2