AGENCY REGISTRATION

Agency: ____
Agency's Complete Name

CDC+ Medicaid Group Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Mailing Address: ____

____

____________________ ______ ________
City State Zip Code

Phone Number: (______) ____________________

Fax Number: (______) ____________________

E-Mail Address: ____________________________

OFFICE USE ONLY	INITIAL	DATE
Received by Area Office		
Sent to Central Office		
Received by Cent. Office		
Assigned to		
Entered into db		

This agency has or has applied for a Specialty Code for CDC+ Consultant Services.

Signature: ____________________________ Date: __________

Print Name: ____________________________

Title: ____________________________

CDC+ MOA between the above Agency and the APD Area _____ Office has been executed.

CDC+ Area Liaison Signature:____________________________ Date: __________

Instructions: *This form is to be completed only by an agency's authorized representative and must be completed before any CDC+ consultant employed by the agency may be selected by a CDC+ consumer to provide or bill for consultant services.* Complete the entire form. **Please type or print legibly!**

The CDC+ Medicaid Group Provider Number is a 9-digit Medicaid number assigned to your agency by the Medicaid Fiscal Intermediary.

Please instruct all consultants employed by your agency of the correct mailing address and the correct Medicaid Group Provider Number for CDC+ in order for them to register as consultants.

Complete and sign a CDC+ Memorandum of Agreement with each Area Administrator of the APD Area in which you provide services. Return this form to the APD Area Liaison for CDC+. Thank you you.