NEW MEXICO
Family Infant Toddler Program

FIT 2nd CME Approval Form

Provider Agency Name:
Child's Name:
D.O.B.:
1st CME Date:
Child transferred from another EI program: ☐ yes ☐ no EI Name:
☐ Medicaid ☐ SGF Unit Rate: $630.00 Code: 7000023
Please justify the need to conduct a 2nd CME: ☐ Re-enrollment is less than 6 months ☐ New concerns ☐ Other
Additional Information Requested:
Person completing the Form: Phone: Email:
Please fax this form to (866-829-8838) to the attention of the FIT Regional Manager listed below:

Sbicca Brodeur Region III Provider Manager	Jonetta Martinez-Pacias Region IV Provider Manager	Yvette Dominguez Region I Provider Manager	Vacant Region II Provider Manager

DDSD Use Only

Review Date: _____ Date Returned to Provider: _____

Approved:☐ Not approved:☐ Reviewer' Signature: _____

FIT Staff please note:

If child is enrolled in Medicaid, instruct provider to bill for second CME via the Medicaid Portal once they receive the approved form. If not enrolled in Medicaid, send the approved form to central FIT Office for adjustment to DOH Invoice.

Comments: