

EFFECTIVE DATE CHANGE REQUEST FORM

Please provide all of the information requested below.

Date: _____

Billing Provider Information

Facility/group practice name

Organization NPI number

Business location (city, state)

Contact name

Contact phone number

Contact email address

Contact mailing address

Servicing Provider Information

Servicing individual provider name

Individual NPI number

Effective Date Change Request Information

Date of requested effective date change for billing group/facility provider

Date of requested effective date change for servicing provider

Dollar amount in claims

Diagnosis codes on claims

Procedure codes on claims

Reason for effective date change request

- Emergency services
- Out-of-state services
- Retroactive client eligibility
- Letter attached
- Claim attached

All effective date change requests must meet the criteria listed in Washington Administrative Code (WAC) 182-502-0005 available at <http://apps.leg.wa.gov/wac/default.aspx?cite=182>.

**Mail this form and any attachments to:
Provider Enrollment, P.O. Box 45562, Olympia, WA 98501-5562**