  Approved Initial

Not Approved Initial

**EFFECTIVE DATE CHANGE REQUEST FORM**

|  |  |
| --- | --- |
| **Please provide all of the information requested below.**  **All Providers must submit this form along with a Letter of Explanation and Copy of Claim(s).** | 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 | |
|  | |

**The required Letter of Explanation should describe the emergent nature and medical necessity of unpaid claims for services provided prior to the HCA effective date, and any mitigating circumstances**

**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**](http://apps.leg.wa.gov/wac/default.aspx?cite=182)**.**

**Mail, Fax, or Email Completed form to:**

**Address: Provider Enrollment, PO Box 45562, Olympia, WA 98501-5562**

**Fax: 360-725-2144**

**Email: providerenrollment@hca.wa.gov**

**Questions? Toll-Free 1-800-562-3022, Extension 16137**