Provider Change Form

Instructions For Completing the Provider Change Form

The Change Form should be used to perform the following:
Change the contact person.
Change the "Doing Business As" (DBA) name.
Change phone number.
Change the email address (for remittances and correspondence).
Change the mailing address.
Add additional records under the same Taxpayer Identification Number (TIN).

Note:
If writing instead of typing, please PRINT clearly in blue or black ink only. Forms will not be accepted if they have whiteout, have been crossed off, or have been written over.

Part A – Identification Details:
You MUST provide your Statewide Vendor Number.
If you do not know your Statewide Vendor Number use the VENDOR LOOKUP page.
You must provide your legal name as filed with the IRS.
You must provide your DBA if you have one.
You MUST provide your Social Security Number (SSN) OR Employer Identification Number (EIN).

Part B – Changes to Be Made:
If you are a business, a contact person's name MUST be provided.
Use the check boxes provided if you wish to add an additional record or change an existing record.
You must complete the entire form for each additional record.

Signature Block:
Please sign with a pen (a "wet signature").
Electronic, inserted or stamped signatures will not be accepted.
This form is not considered valid unless it is signed.

Important:
If you wish to change your legal name or tax type, DO NOT fill out this form. Please complete a registration form.

Submitting the Provider Change Form:
Please PRINT and SIGN the completed form
SCAN to PDF format and EMAIL to: ProviderFileUnit@dshs.wa.gov
MAIL to: DCYF, PO Box 45812, Olympia, WA 98504

For questions about the form, please contact the Payee Registration Unit at (360) 407-8180 ext. 5 or any other questions, please contact the agency you are expecting payment from.

Office of Financial Management
Better information. Better decisions. Better government. Better Washington.

PLEASE DO NOT STAPLE

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Important: For changes to existing registrations, you will be contacted via your registered email, or telephone number, or physical mailing address to verify this change. Changes will not take effect until we have been able to successfully verify the change with the contact person on file.

PART A: Enter Identification Details – ALL FIELDS REQUIRED

Statewide Vendor Number: **S W V** -

Legal Name: _____

DOING BUSINESS AS (DBA): _____

SSPS # (if known): _____

Merit Provider # (if known): _____ Merit Stars # (if known): _____

Taxpayer Identification Number: (SSN or EIN) _____

PART B: Changes to be made

☐ Check this box to **add** an additional record, complete entire form.

☐ Check this box to **change** an existing record. Only enter fields you wish to change.

Contact Person: _____

DBA (Doing Business As): _____

Telephone Number: _____

Email: _____

Mailing Address: _____

(Number, street, and apt, or suite number)

City, State, and ZIP code: _____

_____ _____

Authorized Representative (Please Print) Title

_____ _____

SIGNATURE of Authorized Representative Date: This form is valid for 90 days