



## 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](mailto: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.



PLEASE DO NOT STAPLE

Provider Change Form

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