Provider Request for Alternate Effective Date

The effective date of an applicant's enrollment as an Idaho Medicaid provider is deemed to be the date the application has been fully reviewed by Gainwell Technologies Provider Enrollment and when necessary, IDHW. An alternate effective date of up 365 days prior to the current date is allowed to be input for a service location or affiliated rendering provider in the Provider Enrollment Application system and may be approved when the location or provider is covered by an applicable license, certification or other required credential for approval.

In rare circumstances the requested effective date may be greater than 365 days prior to the current date. Approval may be granted if the services were emergent in nature and indicated as so on the claim or if specialty care that was not otherwise accessible was rendered. Determination is approved by IDHW. In this situation the request must:

- Be supported by a claim for the rendering provider/location and chart notes that reflect the requested effective date, and
- Be noted below and covered by an applicable license, certification or other required credential for approval.

Complete the request form and include a copy of the claim and chart notes that reflect the same requested effective date to support the request. Email the completed form with your case number included to idproviderenrollment@gainwelltechnologies.com.

Requested Effective Date _____/_____/_____

Pay-to Provider NPI/Atypical Number _____

Pay-to Provider NPI/Atypical Name_____

☐ Service Location 3-digit Identifier and Name -_____ _____

☐ Rendering Provider NPI and Name_____

PROVIDER STATEMENT

I certify that I am the provider, or am authorized on behalf of the provider to sign this documentation.

I certify this is true, correct, and complete. If I become aware that any information in this document is not true, correct, and complete, I will notify Idaho Medicaid of this fact immediately.

I authorize Idaho Medicaid to verify the information contained herein. I understand that a change in the ownership of my organization or my status as an individual or group biller may require a new application.

Provider Name:_____ Title:_____

Please print

Provider Authorized Signature:_____ Date:_____