COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services
PRIMARY ACCOUNT HOLDER FORM

Instructions for Primary Account Holder (PAH) Requests or Updates:
Thank you for your request to add or update your Primary Account Holder (PAH) information. Please read the following information to complete this form. Incorrect or incomplete information submitted may cause delays or rejection of this request. All submitted documentation will be validated prior to any updates made.

Required Information Details *
Submit one form for each Entity Tax ID enrolled with DMAS

- Only a single user can be designated the role of Primary Account Holder for each entity.
- An individual designated as a disclosed Individual Provider, Owner (CEO) or other Officer of Company must sign and date this PAH Update Form.
- The Virginia Medicaid Provider Portal Primary Account Holder Change Form requires disclosure and validation of the Pay to address for the provider entity.
- The New PAH email address must be unique and different from any previously used email address. If you are already able to login and access PRSS with this email address, then it cannot be used as the PAH email address.
- If the disclosed individual on file is not current or you are unsure of the disclosed individual on file, then complete section B by following these additional instructions:
  - Name of the current financial institution on file for Electronic Funds Transfer (EFT)
  - Previous Pay to Address (if different from current Pay to Address)
  - IRS Address
  - Provide Name of individual accepting responsibility for the request to grant PAH access (liability)
- Completed forms should be faxed or emailed to:

  Virginia Medicaid Provider Enrollment Services
  PO Box 26803
  Richmond, VA 23261-6803
  804-270-7027 (Fax) or 888-335-8476 (Fax)
  vamedicaidproviderenrollment@gainwelltechnologies.com

SECTION A: Primary Account Holder Request and Update Form

PLEASE NOTE: Handwritten forms may be subject to PAH processing delays

Required Information *	**Required Information**
Individual or Organization Name*****	
Atypical (API) or National Provider Identifier (NPI) used as a servicing or billing provider*****	
Tax Identification Number (TIN, FEIN, SSN) *****	
Pay to Address ***** (Except for Individual within a Group) ***OR*** Provide the last two (2) remittance advice amounts for an NPI associated with your Tax Identification Number	
Current PAH First and Last Name (PAH being replaced)	
Current PAH Email Address (PAH being replaced)	
New PAH First and Last Name *****	
New PAH Email Address * (Previously used Email addresses will be unable to be processed)	
New PAH Mobile Phone Number for Multi Factor Authentication (MFA)	
Brief description why the PAH needs to be changed: *****	

Printed Name:_____ **Title:**_____

Authorized Signature:_____ **Date:**_____

SECTION B: If Disclosed Individual Not Current or Unknown

PLEASE NOTE: At least two of the 3 fields must match the provider file to be approved.

Additional Required Information	
Name of the current financial institution on file for Electronic Funds Transfer (EFT)	
Previous Pay to Address (if current address listed above is unknown)	
IRS Address	
Name of individual accepting responsibility for the request to grant PAH access (liability)	

Printed Name:_____ **Title:**_____

Authorized Signature:_____ **Date:**_____