



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. This form and required information are needed and will be validated prior to any updates being made.

Required Information *

Submit one form for each Entity Tax ID enrolled with DMAS

- An individual designated as a disclosed Individual Provider, Owner (CEO) or other Officer of Company must sign and date this PAH Update Form. This information will be validated prior to any updates being made.
- If the disclosed individual on file is not current or you are unsure of the disclosed individual on file, then follow these additional instructions:

Please submit the following on signed company letterhead:

- Description of why disclosure is not currently on file
- Name of individual accepting responsibility for the request to grant PAH access (liability)
- DOB of individuals that are being granted access/have signed the form
- Last 4 digits of the individual SSN
- Only a single user can be designated the role of Primary Account Holder for each entity.
- The Virginia Medicaid Provider Portal Primary Account Holder Change Form requires disclosure and validation of the Pay to address for the provider entity.
- 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



Primary Account Holder Request and Update Form

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) <i>OR</i> 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 *	
New PAH Mobile Phone Number for Multi Factor Authentication (MFA)	
Brief description why the PAH needs to be changed: *	

Authorized Name: _____ **Title:** _____

Authorized Signature: _____ **Date:** _____