COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Provider Enrollment Services

ACCESS REQUEST

Professional Fillable Form

Form Version 08/2026

COMPLETE ELECTRONICALLY - NO HANDWRITTEN FORMS. Complete the provider information for every request, select all request types that apply, and complete only the matching section(s). **Digitally sign**, save the completed PDF, and email it to VAMedicaidProviderEnrollment@gainwelltechnologies.com. **Authorized signers must be owners and/or managing employees listed on the provider portal.**

PROVIDER IDENTIFICATION - REQUIRED FOR EVERY REQUEST

* Required

NPI/API*

Provider/Business Name*

Service Location ID*

Enrollment Type*

Select Enrollment Type

Enrolled Provider IRS Tax ID*

Enter the IRS tax identification number associated with the enrolled provider record.

REQUEST TYPE - SELECT ALL THAT APPLY

Complete only the corresponding numbered section(s) below.

1A. Primary Account Holder (PAH) - New

1B. Primary Account Holder (PAH) - Change

2. Authorized Administration Access

3. Add Owner/Managing Employee

1. PAH ACCESS OR CHANGE

* Required

Pay-to Address*

Current PAH Name (first and last)

Current PAH Email Address

NEW PAH Name (first and last)*

NEW PAH Email Address (must be unique)*

NEW PAH Mobile Phone for MFA

Reason for Change*

Select a reason...

2. AUTHORIZED ADMINISTRATION ACCESS

AFFILIATION REQUIRED: The Individual within a Group or Ordering, Prescribing and Referring individual must be affiliated to the organization Service Location ID above.

Individual Name*

Social Security Number*

Date of Birth* (MM/DD/YYYY)

Individual NPI*

Individual Provider 14-digit Service Location ID

3. ADD OWNER / MANAGING EMPLOYEE

USE ONLY WHEN THERE IS NO ACTIVE PAH ON THE ACCOUNT.

Owner Name

Managing Employee Name

Date of Birth

Social Security Number

Address Line 1

City

State

Zip +4

% Ownership (required for owner)

%

Enter the information for the person being added. Complete either the Owner Name or Managing Employee Name, as applicable.

AUTHORIZED SIGNER CERTIFICATION

Digital signature required

AUTHORIZED SIGNER REQUIREMENT: The signer must be an **Owner or Managing Employee listed on the provider portal** for the Group/Facility identified above.

Authorized Signer Printed Name*

Last 4 SSN*

Date* (MM/DD/YYYY)

Authorized Signer Digital Signature*