COMMONWEALTH OF VIRGINIA

Department of Medical Assistance Services - Provider Enrollment Services

UPDATE PROVIDER INFORMATION REQUEST

Rev. 08/2026

Complete electronically and save. Email the completed form and supporting documentation to VAMedicaidProviderEnrollment@gainwelltechnologies.com.
DO NOT PRINT AND HANDWRITE THIS VERSION. Use the digital signature field in Section 4.
Complete all fields in Sections 1 and 4. Complete only the applicable detail fields for each selected update. Signature date cannot be older than 90 days.

1. PROVIDER IDENTIFICATION - REQUIRED FOR EVERY REQUEST

NPI or Atypical Provider Identifier (API) *

Provider / Business Name *

Service Location ID *

2. SELECT EACH REQUESTED UPDATE

- ☐ General Information
- ☐ Address / Contact
- ☐ ATN Email Access
- ☐ Add FFS to Contracts (MCO-only)
- ☐ Add TDO to Contracts

3. UPDATE DETAILS - COMPLETE ONLY THE APPLICABLE SECTION(S)

GENERAL INFORMATION UPDATE

New Legal Name (last name only for individuals)

New Date of Birth (MM/DD/YYYY)

Social Security Number - Add Only

ENROLLMENT / REVALIDATION ATN EMAIL ACCESS UPDATE

ATN Number *

New ATN Email Address *

Last 4 Tax ID *

Business Name *

Provider DOB *

ADDRESS / CONTACT UPDATE DETAILS

LIMITED RISK ONLY: Some address changes require a new application. Organizations must attach each applicable site-specific license.
For multiple locations, use only when all affected locations share the same Tax ID. Service-address changes apply to the identified Service Location ID.

Address Scope *

Apply update to at least one address type:

- ☐ Service
- ☐ Pay To
- ☐ Mail To
- ☐ IRS
- ☐ Remit To
- ☐ Site-specific license attached

New Service Address - Line 1

Line 2

State

City - type to search or use dropdown

5-Digit ZIP

New Pay To / Mail To / IRS / Remit To Address - Line 1

Line 2

State

City - type to search or use dropdown

5-Digit ZIP

New Email Address

Phone Number

Fax Number

4. AUTHORIZED SIGNER AND DIGITAL SIGNATURE

Signer must be the enrolled individual for Individual, IWG, or OPR records, or an Owner/Managing Employee currently listed in the PRSS Provider Portal.

Printed Name *

Signer Role *

Last 4 SSN *

Date (MM/DD/YYYY) *

AUTHORIZED DIGITAL SIGNATURE *

Click the box below to digitally sign in Adobe Acrobat/Reader.

SIGN

Click to digitally sign