COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Provider Enrollment Services

TERMINATION REQUEST FORM

Complete this form electronically. Handwritten forms will not be accepted. Apply the authorized signer's digital signature, save the completed PDF, and email it to VAMedicaidProviderEnrollment@gainwelltechnologies.com for processing. Fields marked * are required when applicable.
Complete only the section for the request type selected. If an end date is left blank, the date processed will be used.

1. PROVIDER RECORD INFORMATION

NPI or Atypical Provider Identifier (API) *

Enrollment Type *
Select Enrollment Type

SSN / EIN Tax ID * *(based on Enrollment Type)*

Provider / Business Name *

Service Location ID *

2. REQUEST TYPE AND DETAILS

SELECT ONE REQUEST TYPE *

☐ End date an Individual within a Group (IG) or Ordering, Prescribing, Referring (OPR) affiliation

☐ Terminate the provider enrollment or the service location identified above

A. AFFILIATION END DATE

Complete when the first request type is selected.

Affiliated Group / Facility Name(s) *

Group / Facility Service Location ID(s) *

Requested Affiliation End Date (MM/DD/YYYY)

B. PROVIDER OR SERVICE LOCATION TERMINATION

Complete when the second request type is selected.

Termination Applies To *

☐ Entire Provider Enrollment ☐ Service Location Listed Above

Reason for Termination *
Select reason...

Requested Termination End Date (MM/DD/YYYY)

3. AUTHORIZED SIGNER AND DIGITAL SIGNATURE

Signer eligibility: The authorized signer must be an **Owner** or **Managing Employee** currently listed in the Provider Portal for the provider, group, or facility identified above.
Certification: By applying a digital signature, the signer certifies that the request is accurate and authorized.

Authorized Signer Name (First and Last, Printed) *

Role *
Select...

Last 4 SSN *

Date Signed *

Authorized Signer Digital Signature *

Click the field in Adobe Acrobat or Reader to apply the digital signature.