

GATEWAY HEALTH PLAN®

Practice/Provider Change Request Form

All practice changes must be submitted in writing with the appropriate documentation at least 60 days prior to the effective date. Gateway will make reasonable effort but cannot guarantee that practice changes submitted with less than 60 days notice will be implemented by the requested effective date. TIN changes will only be made on a prospective basis from the date Gateway is notified in writing.

Practice Information:

Gateway ID#:	Practice Name:		
Federal Tax ID#:	Specialty:		
Contact Person Name:		Contact Person Phone:	

What is Changing?

Please check all that apply:

- Gateway participating provider joins your practice: **Attach W9 Form and complete section A on reverse side**
 ➤ **Has provider left his/her current practice?** Yes No
- Non-participating provider joins your practice. **(Please contact your Provider Relations Representative to obtain an application for credentialing.)**
- Provider moves to an existing location within your practice. **(Complete section A beginning below)**
- A participating provider is terminating from your practice. **(Complete section D on reverse side)**
- Practice Name Change. **(Attach W9 Form and complete section A beginning below)**
- Tax ID, Vendor, or Billing Address Change. **(Attach W9 Form and complete section B on reverse side)**
- Addition of New Practice Location or Credentialing Address for Participating Practice. **(Complete section(s) A, B, & C on reverse side)**
- Office Location is closing. **(Complete section A beginning below)**
- Office Panel or Age Restrictions are changing. **(Complete section C on reserve side)**
- E-mail address has changed **(Complete section A beginning below)**
- Updated NPI Number
- OTHER: **Please describe in detail:**

Mail this form to:
Gateway Health Plan®
Attn: Provider Relations Department
U S Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219
Telephone: 1-800-887-1898
Fax: 412/255-4504

Signature: _____
Title: _____

Section A Effective Date: _____ **(Required for ALL CHANGES)**

Physician Name <i>(if applicable)</i> :	Practitioner ID #:	Practitioner NPI #:	Physician Specialty:
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This Location is: **New** **Existing** **Result of Office Move** **Closing**
This Location is: **Primary** **Alternate** **Billing** **Credentialing** **Mailing**

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Section A continued

Address									
City			State		Zip		County		
Phone		Fax			E-mail				
Do you want this office to be listed in Directories? Yes No									
Please list the patient scheduling hours for list office		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		Sunday

(To List Additional Locations, Copy and Attach)

Other Physicians at this Location or use this location as credentialing address:

Practitioner Name	Practitioner ID & NPI #	Practitioner Name	Practitioner ID & NPI #
1.		2.	
3.		4.	

(For Additional Physicians, Attach Sheet)

Section B Effective Date: _____ *(Required)*

Billing Name/Tax ID (Name to appear on check if different from Practice Name. Must be an exact match to the name on file with the Internal Revenue Service for the Tax ID below.)				
Billing Name:	Old:	New:		
Tax ID:	Old:	New:		
Address				
City		State	Zip	County
Phone	Fax		E-mail	

Section C Effective Date: _____ *(Required)*

If participating with Gateway Health Plan® Medicaid, complete the below section.

Medicaid Office Restrictions	Gateway Medicaid Current Information			Gateway Medicaid New Information		
Panel Limit						
Panel Status*	Open	Existing Only	Closed	Open <i>Accepting both new and existing patients</i>	Existing Only <i>Accepting established patients only</i>	Closed <i>Not accepting new or established patients.</i>
Age Restriction	Age _____ and Younger Older			Age _____ and Younger Older		

If participating with Gateway Health Plan Medicare Assured® HMO SNP, complete the below section.

Office Restrictions	Medicare Assured® Current Information			Medicare Assured® New Information		
Panel Limit						
Panel Status*	Open	Existing Only	Closed	Open <i>Accepting both new and existing patients</i>	Existing Only <i>Accepting established patients only</i>	Closed <i>Not accepting new or established patients.</i>
Age Restriction	Age _____ and Younger Older			Age _____ and Younger Older		

*Panel must remain open until minimum contract panel limit is met.

Section D Effective Date: _____ *(Required)*

Physician is terminating from your practice:

Physician Name:	Reason for Termination:	If Relocating, Provide New Address:
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