



# Gateway Health Plan

## Medicare Assured<sup>®</sup> HMO SNP

### Member Outreach Form

**The information in this box is required. Please complete all lines.**

Member Name:

Gateway Health Plan<sup>®</sup> ID #:

DOB:

Phone #: (     )

PCP Name & Provider ID#:

Date of Last Office Visit:

***Member is being referred for the following:***

Chronic no shows for appointment or follow-up care: (please list dates of missed appointments and reason for the appointment) \_\_\_\_\_

Member Education Regarding Appropriate Emergency Use

Referred for services and requires follow-up from Gateway Outreach Representative: (please be specific) \_\_\_\_\_

***(A Gateway Health Plan<sup>®</sup> Representative will telephonically contact the member and provide education, assist with scheduling appointments and assist with transportation as appropriate)***

Comments/Additional Information:

PCP Contact Person:

PCP Phone Number:

Date of Request:

**Mail To:**

**Care Management Department  
Gateway Health Plan<sup>®</sup>  
US Steel Building, Floor 41  
600 Grant Street  
Pittsburgh, PA 15219**

**- or -**

**Fax To:**

**Care Management Department  
Fax: (412) 255-4261 or  
(888) 225-2360**

If you have questions concerning the use of this form, call the Care Management Department at 1-800-685-5212, press 4.