



Gateway Health Plan Medicare Assured[®] HMO Member Outreach Form

The information in this box is required. Please complete all lines.	
Member Name: _____	
Gateway Health Plan [®] 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[®] 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[®]
US Steel Building, Floor 41
600 Grant Street
Pittsburgh, PA 15219

- or -

Fax To:
Care Management Department
Fax: (412) 255-5639 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.