

Gateway Health Plan
Medicare Assured[®] HMO SNP
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) 255-4261 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.