Gateway Health Plan®
Member Outreach Form

The information in this box is required. Please complete all lines.	
Member Name:	AGE:
Gateway Health Plan® ID #:	DOB:
Date of Last EPSDT screen (for members <21 years old)	
Parent/Guardian Name:	Relationship:
Phone #: ( )	
PCP Name	Provider ID#:
PCP Contact Person:	PCP Contact Phone #:
Date sent to GHP:	

Member is being referred for the following:

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

- Over due for EPSDT screen – Last Screen date: _____
- Behind on these immunizations: _____
- Chronic no show for appointments or follow up care: (list dates missed)
  _____
  Reason for Appointment: _____
- Elevated Blood Lead Level
  Date of last draw: _____ Result of last draw: "_____"
  Date script was given for Blood Lead Level _____
  Notified by mail (attach letter) Notified by phone call on: _____
- Member Education Regarding Referral Use
- Referred for services: Services needed: (***Be Specific***)
  _____
  Referred to Physician: _____ Phone # _____

Comments or Addition Information: _____
_____
_____
_____
_____

Mail To: ***- or -*** ***Fax To:***

Preventive Health/EPSDT Department
Gateway Health Plan®
US Steel Building, Floor 41
600 Grant Street
Pittsburgh, PA 15219

Preventive Health Department
Fax: (412) 255-5639 or
(888) 225-2360

If you have questions concerning the use of this form,
call the Preventive Health Department at 1-800-642-3550, press 4.

10/04; revised 10/05; 04/09, 12/09, 1/11