



Gateway Health Plan[®] Member Outreach Form

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

Member Name:

Gateway Health Plan[®] ID #:

DOB:

Parent/Guardian Name:

Phone #: ()

PCP Name & Provider ID#:

Date of Last EPSDT screen (for members <21 years old):

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)

- Elevated Blood Lead Level, date & result of last draw _____
- Script given for Blood Lead Level, date _____
- Behind for these immunizations _____
- Overdue for EPSDT screen
- EPSDT referral to a dental home
- Chronic no shows for appointment or follow-up care: (please list dates of missed appointments and reason for the appointment) _____
- Member Education Regarding Referral Use
- Referred for services and requires follow-up from Gateway Outreach Representative: (please be specific) _____

Comments/Additional Information:

PCP Contact Person:

PCP Phone Number:

Date of Request:

Mail To:

- or -

Fax To:

Preventive Health/EPSDT Department

Preventive Health Department

Gateway Health Plan[®]

Fax: (412) 255-5639 or

US Steel Building, Floor 41

(888) 225-2360

600 Grant Street

Pittsburgh, PA 15219

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