

Please refer to the DIVA Instructions listed in the Reference Materials Section of Gateway's Website for instructions on how to use our electronic referral system:

[Cheat Sheet--DIVA Instructions on Reviewing Referral](#)

[Cheat Sheet--DIVA Instructions on Entering Referral](#)

For additional copies of this referral form:

Contact your Gateway Provider Relations Representative
or Call Provider Servicing at 1-800-392-1145.

Mail to:
Gateway Health Plan
P.O. Box 11-718
Albany, NY 12211-0718

GATEWAY HEALTH PLAN OB/GYN REFERRAL FORM

PLEASE PRESS FIRMLY
YOU ARE MAKING 4 COPIES

PROVIDER INFORMATION

OB/GYN Provider Name: _____

OB/GYN Provider # : _____

OB/GYN Address: _____

Provider Phone #: _____

Automated telephone referrals may be done through Gateway's
DIVA/EVS line at 1-800-642-3515

PATIENT INFORMATION

Patient Name: _____

GHP Member ID #: _____

Diagnosis/Complaint: _____

Designated Laboratory: _____

FACILITY INFORMATION

REFERRED TO:

Facility Name: _____

Facility Provider ID #: _____

REFERRAL IS VALID FOR 90 DAYS FROM THE DATE OF ISSUE (With the Exception of ER Visits)

**Members Must Be Referred To Specialists Through Their Primary Care Practitioner With The
Exception of Perinatologists Who Do Not Require a Referral.**

Referred Services:

Lab Testing Performed by a Non-Designated Lab - 3 Visits/90 Days
(Specify) _____

Must use designated laboratory except in an emergency.

Other Outpatient Diagnostic Testing - 3 Visits/90 Days
(Specify) _____

ER Visit (ER Visit Date Required) _____

Other (specify) _____

- > The referral must be in Gateway's claim system at the time the bill is received to be applied to the service rendered.
- > Payment for referral and precertified services is contingent upon the patient being an effective Gateway member on the date of service at the time of claims processing.

OB/GYN Signature: _____

Referral Date: _____ - _____ - _____ (If referral is not dated, Gateway will date according to receipt date at the claim office.)

OB/GYN RETURN TO GATEWAY