ON-CALL PRIMARY CARE PRACTITIONER COVERAGE AGREEMENT

Gateway Health Plan® (Gateway) has developed a program for the delivery of healthcare services to the Medicaid population. Gateway members select a primary care practitioner (PCP) who serves as the case manager for the provision of all Gateway benefits including referral services. As the physician(s) who provides on-call coverage for _____, a Gateway affiliated PCP, I agree to the following:

I will provide medical care to members only when covering for the Gateway affiliated physician(s). I will refer the member back to that physician for follow-up unless the member requires immediate medical care beyond the scope of our practice; in those instances I will attempt to refer the member to a Gateway affiliated practitioner by calling Gateway at 1-800-392-1146. I will notify Gateway within 24 hours of any emergency and all other admissions of which I am aware. When the affiliated physician is unavailable and a member requires admission, I will obtain authorization, if at all possible, from Gateway and will admit to a Gateway affiliated hospital. I will not charge or collect any amounts from members for any covered services I provide. Instead, I will look to the above named physician(s) for reimbursement for covered services I provide.

I affirm that I have malpractice insurance in minimum amounts as required by the Commonwealth of Pennsylvania, that I am at all times acting as an independent contractor, and that Gateway will not be responsible for any alleged acts of professional liability which are asserted against me in the course of my professional practice.

I certify that I presently maintain staff privileges at _____ Hospital(s), that my privileges at the above Hospital(s) and/or any other hospitals with which I have been affiliated have not in any way been reduced, restricted or revoked, that my license(s) to practice medicine has never been suspended, revoked or otherwise adversely affected in Pennsylvania or any other jurisdiction, and that I am not currently, nor in the past, been under investigation, indictment or prosecution for any offense related to the delivery of an item or service under the Medicare or Medicaid Programs.

_____

Signed

_____ _____

Print Name Date

_____ _____

Medical Director Date

Revised 2/2010