GATEWAY
Health Plan®

ON-CALL SPECIALTY CARE PRACTITIONER COVERAGE AGREEMENT

Gateway Health Plan® (Gateway) has developed a program for the delivery of healthcare services to the Medical Assistance population. As the physician(s) who provide on-call coverage for _____, a Gateway affiliated specialist, I agree to the following:

I will provide medical care to members only when covering for 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 bill Gateway for covered services rendered to members. I agree to accept as payment in full the reimbursement rendered by Gateway.

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