



GATEWAY HEALTH PLANSM PENNSYLVANIA MEDICAID Practice/Provider Change Request Form

All practice changes must be accompanied by the appropriate documentation. A confirmation letter with effective dates will be mailed to you once the change(s) has been made. Please note: **all** changes must have an **effective date**.

Practice Information:

| | |
|----------------------|-----------------------|
| GATEWAY ID#: | Practice Name: |
| Federal Tax ID#: | Specialty: |
| Contact Person Name: | Contact Person Phone: |

What is Changing?

Please check all that apply:

Gateway participating provider joins your practice: **Attach W9 Form and complete section A on reverse side**

➤ **Has provider left his/her current practice?** Yes No

Non-participating provider joins your practice. **(Please contact your Provider Relations Representative to obtain a complete application)**

Provider moves to an existing location within your practice. **(Complete section A on reverse side)**

Provider adds a location at an existing office within your practice. **(Complete section A on reverse side)**

A participating provider is terminating from your practice. **(Complete section D on reverse side)**

Practice Name Change. **(Attach W9 Form and complete section A on reverse side)**

Tax ID, Vendor, or Billing Address Change. **(Attach W9 Form and complete section B on reverse side)**

New Location for Existing Practice. **(Complete section(s) A, B, & C on reverse side)**

Office Location is Closing. **(Complete section A on reverse side)**

Office Restrictions are Changing. **(Complete section C on reverse side)**

E-mail address has changed **(Complete section A on reverse side)**

NPI Number Update

OTHER: **Please describe in detail:**

**NOTE: CHANGE MAY
AFFECT CAP LEVEL**

Gateway Health PlanSM
Attn: Provider Relations Department
US Steel Tower, Floor 41
600 Grant Street
Pittsburgh, PA 15219
Telephone: 1-800-392-1145
Fax: 412/255-4504

Provider Signature: _____



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Section A Effective Date: _____ (Required)

| | | | |
|---------------------------------|--------------------|---------------------|----------------------|
| Physician Name (if applicable): | Practitioner ID #: | Practitioner NPI #: | Physician Specialty: |
|---------------------------------|--------------------|---------------------|----------------------|

This Location is: **New** **Existing** **Result of Office Move** **Closing**
This Location is: **Primary** **Alternate** **Billing** **Mailing**

| | | | | | | | |
|--|--|--------|---|-----------|----------|--------|--------------------|
| Address | | | | | | | |
| City | | | State | | Zip | | County |
| Phone | | Fax | | | E-mail | | |
| Is this office wheelchair accessible? Yes No | | | Do you want this office to be listed in Directories? Yes No | | | | |
| Please list the patient scheduling hours for list office | | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday Sunday |

(To List Additional Locations, Copy and Attach)

Other Physicians at this Location:

| Practitioner Name | Practitioner ID & NPI # | Practitioner Name | Practitioner ID & NPI # |
|-------------------|-------------------------|-------------------|-------------------------|
| 1. | | 2. | |
| 3. | | 4. | |

(For Additional Physicians, Attach Sheet)

Section B Effective Date: _____ (Required)

| | | | |
|--|------|--------|-----|
| Billing Name/Tax ID (Name to appear on check if different from Practice Name. Must be an exact match to the name on file with the Internal Revenue Service for the Tax ID below.) | | | |
| Billing Name: | Old: | New: | |
| Tax ID: | Old: | New: | |
| Address | | | |
| City | | State | Zip |
| County | | Phone | Fax |
| | | E-mail | |

Section C Effective Date: _____ (Required)

| Office Restrictions | Current Information | | | New Information | | |
|---|-----------------------|----------------------|---------------|--|--|--|
| Panel Limit | | | | | | |
| Panel Status (Panel must remain open until minimum contract panel limit is met) | Open | Existing Only | Closed | Open <i>Accepting both new and existing patients</i> | Existing Only <i>Accepting established patients only</i> | Closed <i>Not accepting new or established patients.</i> |
| Age Restriction | Age _____ and Younger | | Older | Age _____ and Younger | | Older |
| Capitated Lab | | | | | | |

Section D Effective Date: _____ (Required)

Physician is terminating from your practice:

| | | |
|------------|------------|--------------|
| Who: _____ | Why: _____ | Where: _____ |
|------------|------------|--------------|