Follow the instructions below.

Register Account
Enter your email address and a password to register and begin sending and receiving secure messages.

Email Address:
Password:
Re-enter Password:

Step 1 - Enter your email address
Step 2 - Enter a password
Step 3 - Re-enter your password
Step 4 - Click the register button

Password Rules
Passwords must be at least 8 characters in length, and meet 2 of the following conditions:
- Contain both alphabetic and numeric characters
- Contain both uppercase and lowercase characters
- Contain at least one special character, such as: !@#$%&

For Customer Support, send an email message to support@gatewayhealthplan.com

Secured by zixcorp
Account Change Confirmation

A confirmation email has been sent to your email address for this Gateway Health Plan mailbox. After you receive the confirmation email, please follow the instructions to activate the changes.
Your Gateway Health Plan password is pending.

To ACTIVATE your new password, click the link below:

https://securemail.gatewayhealthplan.com/s/a?cmd=

This is the last step in this one-time process.

To DECLINE your new password, click the link below:

https://securemail.gatewayhealthplan.com/s/d?cmd=

If the link above is disabled, copy and paste it into your Internet browser address bar.
Activation Successful

You have successfully activated your new password. Click Continue to return to the Sign in page.

Note: Your password is important. Please store it in a safe place.
Welcome to the Gateway Health Plan® Message Center

Email Address: 
Enter your email address

Password: 
Enter your password

Remember Me
Click Sign In

Forgot your password? Reset
New to secure email? Register
Need more assistance? Help

For Customer Support, send an email message to support@gatewayhealthplan.com
Click and select Compose
Step 1 - Make a selection
Select “Appeals” to request a pharmacy appeal (Part D Redetermination)
Select "Coverage Determinations" to request an exception to the plan formulary.

Step 2 - Please submit the following information to ensure that your request is processed appropriately:

- Member Name
- Member ID Number
- Member DOB
- Prescriber Name
- Prescriber Phone Number
- Prescriber Fax Number
- Drug Name
- Drug Dose
- Drug Frequency

If available, please provide:
Formulary alternatives tried
Diagnosis

**Please indicate whether or not the member’s health could be seriously harmed by waiting three days for a decision on this request.

**For members of Medicare Assured®, the prescribing physician or other prescriber must submit a statement to support the request for coverage determination.

Step 3 - Click Send