Gateway Health
I'm good with Gateway.

DATE SENT TO GATEWAY_____

GATEWAY ASTHMA CONTROL TEST (ACT) FORM COVER SHEET

MEDICAID MEMBER NAME

_____

MEMBER DATE OF BIRTH

_____

GATEWAY MEMBER ID:

_____

DATE OF SERVICE

_____

PROVIDER NAME

_____

PROVIDER GATEWAY ID

_____

PROVIDER CONTACT NAME

_____

PROVIDER PHONE

_____

QUESTION	YES	NO	DATE OF OUTPATIENT VISIT
WAS THE ACT FORM COMPLETED DURING A 2017 OUTPATIENT VISIT WHERE THE PRINCIPLE DIAGNOSIS WAS ASTHMA?	☐	☐	
WAS THE ACT FORM COMPLETED DURING AN ANNUAL WELL VISIT IN 2017 THAT INCLUDED ANY DIAGNOSIS FOR ASTHMA?	☐	☐	
Providers must answer yes to one of the questions above to qualify for the ACT form submission incentive. This response has to be supported by a corresponding claim.			