Gateway Health Plan®

Certification of Need for Expedited Review

Member Name:

ID Number:

Service/item in question:

I hereby certify that the usual timeframes (30/45 days) for review of a complaint, grievance or Fair Hearing may place this patient's life, health or ability to regain maximum function in jeopardy.

Specify reason(s):

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____________________________________ ____________________
Physician's Signature Date

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Printed Name

Fax this completed form to Gateway Health Plan at 412/255-4503.
To request an Expedited Fair Hearing with the Pennsylvania Department of Public Welfare, fax to 717-772-6328.

Received by: ____

Date/time: ____