GATEWAY HEALTH[SM]
Practice/Provider Change Request Form

All practice changes must be submitted in writing with the appropriate documentation at least 60 days prior to the effective date. Gateway will make reasonable effort but cannot guarantee that practice changes submitted with less than 60 days notice will be implemented by the requested effective date. TIN changes will only be made on a prospective basis from the date Gateway is notified in writing.

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 an application for credentialing.)***
- ☐ Provider moves to an existing location within your practice. ***(Complete section A beginning below)***
- ☐ A participating provider is terminating from your practice. ***(Complete section D on reverse side)***
- ☐ Practice Name Change. ***(Attach W9 Form and complete section A beginning below)***
- ☐ Tax ID, Vendor, or Billing Address Change. ***(Attach W9 Form and complete section B on reverse side)***
- ☐ Addition of New Practice Location or Credentialing Address for Participating Practice. ***(Complete section(s) A, B, & C on reverse side)***
- ☐ Office Location is closing. ***(Complete section A beginning below)***
- ☐ Office Panel or Age Restrictions are changing. ***(Complete section C on reserve side)***
- ☐ E-mail address has changed *(**Complete section A beginning below**)*
- ☐ Updated NPI Number
- ☐ OTHER: **Please describe in detail:**

_____
_____
_____
_____

Mail this form to:
Gateway Health[SM]
Attn: Provider Relations Department
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222
Telephone: 1-800-392-1145
Fax: 1-855-451-6680

Signature:_____

Title:_____

Section A Effective Date: _____ ***(Required for ALL CHANGES)***

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** **Credentialing** **Mailing**

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Section A continued

Address							
City			State	Zip		County	
Phone	Fax			E-mail			
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 or use this location as credentialing address*:*

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)*

If participating with Gateway Health℠ Medicaid, complete the below section.

Medicaid Office Restrictions	**Gateway Medicaid Current Information**			**Gateway Medicaid New Information**		
Panel Limit						
Panel Status*	**Open**	**Existing Only**	**Closed**	**Open** *Accepting both new and existing patients*	**Existing Only** *Accepting established patients only*	**Closed** *Not accepting new or established patients.*
Age Restriction	Age _____ and Younger Older			Age _____ and Younger Older		

If participating with Gateway Health Plan Medicare Assured®, complete the below section.

Office Restrictions	***Medicare Assured®* Current Information**			***Medicare Assured®* New Information**		
Panel Limit						
Panel Status*	**Open**	**Existing Only**	**Closed**	**Open** *Accepting both new and existing patients*	**Existing Only** *Accepting established patients only*	**Closed** *Not accepting new or established patients.*
Age Restriction	Age _____ and Younger Older			Age _____ and Younger Older		

*Panel must remain open until minimum contract panel limit is met.

Section D Effective Date: _____ *(Required)*

Physician is terminating from your practice:

Physician Name:	Reason for Termination:	If Relocating, Provide New Address: