Practitioner Race/Ethnicity and Language Data Form

By providing race and ethnicity data and allowing us to share it with members (upon request), Gateway is able to help connect the appropriate practitioners to the appropriate members. This data will support better provider-patient communication, improve patient's health and overall understanding and compliance with recommended treatments. Please complete, sign and fax to Gateway's Provider Relations Department at **1-855-451-6680**. This form is also available on the Provider page of our website - www.GatewayHealthPlan.com in the Forms and Reference section.

Practitioner Name: _____

(Please print Last, First, MI & Degree)

Practitioner NPI: _____**Gateway Practice Group ID:** _____

Race/Ethnicity

Are you Hispanic/Latino? (choose only one)

- ☐ No, not Hispanic/Latina
- ☐ Yes, Hispanic/Latina (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race)

The above question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider your race to be.

What is your race? (choose one or more)

- ☐ American Indian or Alaska Native. (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains a tribal affiliation or community attachment.)
- ☐ Asian. (A person having origins in any of the peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ Black or African American. (A person having origins I ay of the Black racial groups of Africa.)
- ☐ Native Hawaiian or Other Pacific Islander. (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ White. (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Practitioner's Signature: _____**Date:** _____

(By signing I do hereby attest that the information may be shared with Gateway Health℠ members upon request.)

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