Gateway Health

Provider Update

March 2016

SPECIAL EDITION

NOTICE OF PRACTICE/PRACTITIONER CHANGES!

One of the many benefits to the Gateway Health member is improved access to medical care through Gateway's contracted provider network. To ensure our members have up to date and accurate information on availability it is imperative that providers submit written 60 days advance notice of the following:

- Address changes;
- Phone & fax number changes;
- Changes to hours of operation;
- Primary Care Practice (PCP) panel status changes (Open, Closed & Existing Only);
- Practitioner participation status (additions & terminations) and;
- Mergers and acquisitions

The Gateway Practice/Provider Change Request Form can be completed for conveying practice/practitioner changes or notice on your practice letterhead is acceptable. This form is included with this Provider Update and is also available on www.GatewayHealthPlan.com -- select *Provider*, and then click on *Forms & Reference Materials*.

Please submit your change request via fax or mail.

Fax to: 1-855-451-6680
Mail to: Gateway Health[SM]
Provider Information Management
Four Gateway Center
444 Liberty Avenue, Suite 2100
Pittsburgh, PA 15222-1222

If you have questions about this Provider Update please contact your Provider Relations Representative directly.

Provider Relations Department
Gateway Health[SM]

GATEWAY HEALTH℠
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:

NPI or Gateway ID#:	**Practice Name:**
Federal Tax ID#:	**Specialty:**
Contact Person Name:	**Title:**
Phone:	**Email:**

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 go to www.GatewayHealthPlan.com; select Providers; click on Join Our Network and complete online request to enroll form.)***
- ☐ 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 page 2)***
- ☐ 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 page 2)***
- ☐ Addition of New Practice Location or Credentialing Address for Participating Practice. ***(Complete section(s) A, B, & C on page 2)***
- ☐ Office Location is closing. ***(Complete section A beginning below)***
- ☐ Office Panel or Age Restrictions are changing. ***(Complete section C on page 2)***
- ☐ E-mail address has changed *(**Complete section A beginning below**)*
- ☐ Updated NPI Number
- ☐ **OTHER: Please describe in detail:**

_____
_____
_____
_____

Mail this form to:
Gateway Health℠
Attn: Provider Information Management
Four Gateway Center
444 Liberty Avenue, Suite 2100 Pittsburgh, PA 15222-1222
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**

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 NPI #***	**Practitioner Name**	***Practitioner 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 Primary Care Practice (PCP) complete the below section.

Office Restrictions	**Gateway Current Information**			**Gateway New Information**		
Panel Limit	_____Medicaid _____Medicare			_____Medicaid _____Medicare		
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: