

# Employee Request for Physician Participation In Gateway Health Alliance Network

To be completed by the employee:

My employer, \_\_\_\_\_, has selected Gateway Health Alliance to serve the employee health benefit plan's needs. I am asking that the following health care provider(s) consider participation in the Gateway Health Alliance Network so that my family member(s) and/or I may continue care as "in-network." *I understand that the completion of this form is for nomination purposes only and is neither a guarantee of provider participation, nor a guarantee of benefits.*

\_\_\_\_\_  
Employee Name (Please Print)

\_\_\_\_\_  
Date

Physician Name and Practice Name	Physician Address (Town)	Patient Name (Employee or Dependent)

\_\_\_\_\_  
Employee Signature

Please return completed forms to Gateway Health Alliance Provider Relations Department  
Fax: (434) 799-3837

Or Mail:  
Gateway Health Alliance/Halifax PHO  
Attn: Provider Relations Dept.  
P.O. Box 1120  
Danville, VA 24543