



CAQH Provider Data Form

To begin the credentialing process, please use this simple standardized form. This form represents your intent to join Gateway's network of providers.

Today's Date: \_\_\_\_\_

Last Name:	First Name:	Middle Initial:
Date of Birth:	CAQH Provider Number:	Signature:

\_\_\_\_\_  
Practice Name

\_\_\_\_\_  
Credentialing Contact and Phone Number

\_\_\_\_\_  
E-Mail Address

Gateway Health Alliance  
341 Main Street, Suite 301  
Danville, VA 24541  
Phone 434-799-3838  
Fax 434-799-3837  
Email [cjanke@gatewayhealth.com](mailto:cjanke@gatewayhealth.com)