



Employee Request for Physician Participation

To be completed by the employee:

My employer, _____, has selected Gateway Health 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 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.

Physician Name & Practice Name	Physician Address	Patient Name

Employee Name (Please Print)

Date

Phone Number

E-mail Address

Employee Signature

Please return completed forms to Gateway Health Provider Relations Department

Fax: (434) 799-3837

Or Mail:

Gateway Health Alliance
Attn: Provider Relations Dept.
P.O. Box 1120
Danville, VA 24543