Gap Report Template

PLAN NAME: [Insert Plan Name]

[Insert Site Name] [Insert Tax ID] [Insert Sponsor Name] [Insert Date]

Enrollee Last Name:	First Name:	Middle Initial:	CIN (Medicaid Number):	Gender:	Date of Birth:	Street Address:	City:	Zip Code:	Phone Number:	Area of Service:	Service Period:	Service Notes: (As Needed)	Number of Gaps:	PCP Name:	PCP Phone Number:	Last Service by PCP:
Doe	Jane	A	XX11111Y	Female	1/1/2010	123 Main Street	City	99999	888-888-8888	WCV	1/1/2016-1/1/2017		2	Dr. Mary Cunningham	333-333-3333	3/3/2016
Doe	Jane	A	XX11111Y	Female	1/1/2010	123 Main Street	City	99999	888-888-8888	Immunizations	1/1/2016-1/1/2017		2	Dr. Mary Cunningham	333-333-3333	3/3/2016
Smith	Joe	B	AA00000B	Male	5/5/2005	555 First Street	Town	88888	777-777-7777	Dental	1/1/2016-1/1/2017		1	Dr. James Stevens	444-444-4444	4/4/2015