

**Geisinger Health Plan Outpatient Rehabilitative Therapy Services Network
 OUTPATIENT REHABILITATIVE THERAPY SERVICES REFERRAL FORM**
 Phone: (570) 271-5301 Toll Free: 1-800-270-9981 Fax: (570) 271-5302

FORM A
 (New Case)

SECTION 1 – (to be completed and faxed upon initial visit) *Required information. Incomplete forms will be returned unprocessed.

<u>Member Information</u>	<u>Referral Source</u>	<u>*Rehab Provider Facility Name</u>
*Last Name, First Name, MI:	Referring Physician *First Name, Last Name	Location: *Health Plan Provider #:
*DOB: Address:	*Phone: () *Fax: ()	*Phone # *Fax #:
Phone #: *GHP ID#:	*Service Requested PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/>	*Site of Service: O/P Clinic <input type="checkbox"/> SNF <input type="checkbox"/> Hospital <input type="checkbox"/> CORF <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/>

OTHER INSURANCE INFORMATION: (Workman's Compensation, Auto Insurance, etc.)
 Company: _____ Policy Number: _____ Claim Number: _____ Date of Accident: _____
 Contact Person: _____ Phone Number: _____

DIAGNOSIS INFORMATION

*ICD-9 CODE:	*DESCRIPTION:
SURGICAL PROCEDURES: (Include Dates) _____ Co-Morbidities: _____ Psychosocial Factors: _____	

SECTION 2 –
 Functional level prior to current problem: _____

Current Problems/Duration: (Include specific Clinical Information) Or Eval attached /or 1 visit only Requested

- Goals:
- _____
 - _____
 - _____
 - _____
 - _____

Plan of Care: _____

Therapist Signature: _____ Date: _____

For Geisinger Health Plan Outpatient Rehabilitative Services Network Only

Authorization #:	# of Approved Visits:	Discipline authorized: PT OT ST
------------------	-----------------------	---------------------------------

Approval verifies appropriateness of a level of care and is not a guarantee of payment.

Case Manager Signature: _____ Date: _____

SECTION 1 – * Required information. Incomplete forms will be returned unprocessed.

Last Name	* Member Information		* Member Insurance Identification Number:
	First Name	MI	
			* Total # of Visits Completed to Date:

SECTION 2

* Rehabilitative Facility Name:	
Facilities Health Plan Provider Number:	
* Phone: ()	* Fax: ()
* Treating Therapist's Name (including discipline):	* PT, OT, ST

SECTION 3 – (to be completed and faxed for extension of rehabilitative visits beyond those authorized at initial request)

Current objective clinical findings: See attached progress report

Updated goals:

1. _____

2. _____

3. _____

4. _____

5. _____

Treatment interventions being used: _____

Therapist Signature: _____ Date: _____

For Geisinger Health Plan Outpatient Rehabilitative Services Network Only

Authorization #	# of Approved Visits:	Discipline:
		PT OT ST

Approval verifies appropriateness of a level of care and is not a guarantee of payment.

Case Manager Signature: _____ Date: _____

Auth end date: _____