



Completing the Geisinger Health Plan Prior Authorization Request Form

The Prior Authorization Request Form can be utilized when requesting prior Health Plan authorization for the services listed in the Health Plan's Provider Guide(s) titled "Other Services Requiring Prior Health Plan Authorization".

This form **does not** replace the Outpatient Referral Form and the completed form should be submitted to Health Plan, via fax or mail, **before** services occur.

Step 1: Enter date form was completed.

Step 2: Member information: Clearly print or type the following:

- Member name;
- Health Plan identification number;
- Date of birth; and
- Diagnosis

Step 3: Requesting Provider information: Clearly print or type the following:

- Requesting provider's name
- Requesting provider's address;
- Indicate if requesting provider is Member's PCP
- Requesting provider's telephone number

Step 4: Referral request information: Clearly print or type the specialist and/or facility name that you wish to refer the member. Circle whether the provider is participating or non-participating. Include the address, telephone number, fax number, and specialty of the provider.

Step 5: Services requested information: Clearly indicate the type of requested services.

Step 6: Sign, fax or mail the completed form including the medical document, as applicable, to the address or fax number provided on the bottom of the form.

Upon submission of required information, the Medical Management staff will provide verbal and written notification of the determination of coverage within applicable regulatory timeframes.

All procedures/services are subject to the terms, conditions and limitations of coverage as set forth in the member's applicable Benefit Document.

Please note: *The list of "Other Services Requiring Prior Health Plan Authorization" are subject to change. Please contact the Medical Management Department at (800) 544-3907 option 2 if you have questions regarding prior Health Plan authorization of a particular service.*

In the event prior Health Plan authorization is not obtained; the Participating Provider may be held financially liable for failure to follow the proper protocol when referring members for the procedure(s)/service(s) which require prior Health Plan authorization.

Services are not considered authorized until Health Plan completes a determination of coverage.

Geisinger Health Plan Prior Authorization Request Form

IF REQUEST IS MEDICALLY URGENT, PLEASE CALL 1-800-544-3907 option 2 Monday-Friday 8:00am - 5:00pm.

Date Completed: _____

<p style="text-align: center;">(PLEASE PRINT)</p> Member Name: _____	<p style="text-align: center;">(PLEASE PRINT)</p> Name of Participating Provider making request: _____
Member Identification #: _____	Address: _____
Date of Birth: _____	Is requestor the Member's PCP (circle one): YES NO
Member Diagnosis: _____	Requesting Participating Provider's telephone #: _____

REQUESTING REFERRAL TO: Specialist/Facility

(PLEASE PRINT)

Name of Specialist and/or Facility: _____
(Circle One): Participating Non-Participating

Address: _____

Telephone #: _____ Fax #: _____ Specialty: _____

Covered Services requested (check one or both, if applicable): Physician Facility

Physician Related Services	Consult/Office Visit: YES NO Follow-up Visit: YES NO If Yes, how many visits? _____ Procedure(s) (If applicable) YES NO If yes, list below: (Be specific): _____ _____
Facility Related Services	Inpatient: YES NO Outpatient: YES NO Procedure(s) (If applicable) YES NO If yes, list below: (Be Specific): _____ _____

REASON FOR REQUEST (BE AS SPECIFIC AS POSSIBLE):

Signature of Requesting Participating Provider or Participating Provider's Designee:

Complete form and **mail or fax** to: Geisinger Health Plan
100 North Academy Avenue
Danville, Pa. 17822
Attn: Office of Medical Director 32-20
Fax#: 570-271-5534

Supporting Medical Documentation Attached (circle one): YES NO # pages attached: _____

**SERVICES ARE NOT CONSIDERED AUTHORIZED UNTIL A DETERMINATION
OF COVERAGE IS COMPLETED BY THE HEALTH PLAN**