GEISINGER HEALTH PLAN®

DME AUTHORIZATION CHANGE FORM

PHONE: 866-248-1972
LOCAL: 570-271-7127
FAX: 570-271-7171

*DME VENDOR: *GHP PROVIDER NUMBER:	*LOCATION: *	*PHONE NUMBER: *FAX NUMBER:	*FORM COMPLETED BY:

*CHANGE REQUESTED: ___ Date of Service ___ Change of Equipment ___ Code Change ___ Return/Pick-up ___ Other

*MEMBER ID:

*MEMBER NAME:

*AUTH NUMBER:

*HCPCS authed:

*HCPCS requested:

***Vendor** specific request and reason:

Adjusted date of delivery:

Equipment change date:

Return or pick-up date:

DECISION (Internal use only)

Network Signature: Date completed:

Precertification/authorization verifies medical necessity criteria have been met and is not a guarantee of payment.

*Required Information. Incomplete forms will be returned unprocessed.