GEISINGER HEALTH PLAN®

DME OXYGEN/POSITIVE AIRWAY PRESSURE PRECERTIFICATION FORM

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

*DME VENDOR: *GHP PROVIDER #:	*LOCATION:	*PHONE NUMBER: *FAX NUMBER:	*FORM COMPLETED BY:
*MEMBER INFORMATION: (Last Name, First Name, MI)		*HEALTH PLAN ID:	*BIRTHDATE:
*OXYGEN PRESCRIPTION			
Prescribed Setting (Liter Flow): _____Continuous		_____With Exercise	_____Nocturnal
Testing Facility/Location:		Outpatient Test Date:	
Inpatient/ED Date of Discharge:		Date of Test:	
Test Results: PO2 _____ SpO2 _____	Test Conditions (Rest, exercise, nocturnal)		Room Air? _____ LPM/% _____
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If PO2 = 56-59 or oxygen saturation = 89% which criteria are met? Dependent edema due to CHF? ____			
*POSITIVE AIRWAY PRESSURE PRESCRIPTION			
Testing Facility:	Location:	Outpatient Test Date:	
Circle the appropriate diagnosis: Obstructive Sleep Apnea	Restrictive Thoracic Disorder	Severe COPD Central Sleep Apnea	Hypoventilation Syndrome
Prescribed settings: Pressure:	Rate:	O2 Flow:	
Titration Done: ___yes ___no			

*Required Information. Incomplete forms will be returned unprocessed.

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