GEISINGER HEALTH PLAN®

Outpatient Prior Authorization Form

Please fax completed form to (570) 271-5534.
All required fields (*) must be completed.
Incomplete forms will be returned unprocessed.

Date of Request: (mm/dd/yyyy)	*Member Name:		
Member Medical Record #:	Member ID:	Member DOB:	
*Contact Person:		*Contact Phone:	Ext:
*Requesting Provider (Last Name, First Name):		*Requesting Provider Phone:	
		*Requesting Provider Fax:	
Servicing Provider Name (Last Name, First Name):		Servicing Provider Phone:	
		Servicing Provider Fax:	
*Facility/Location of Service:		Facility Phone:	
		Facility Fax:	
Facility/Location Address:			
Specialty Vendor Name:		Specialty Vendor Phone:	
		Specialty Vendor Fax:	
*Requested Service:			
Anticipated Date of Service/Actual Date of Service: (mm/dd/yyyy)			
Diagnosis:			
*Diagnosis Code(s):			
Diagnosis Description:			
*Procedure Code(s):			
*Name and Phone # of Person Submitting Request:			

In order to process this request supporting documentation must be attached for review.