GEISINGER HEALTH PLAN®

# DME INITIAL PRECERTIFICATION FORM

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

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|---|---|---|---|
| *DME VENDOR:<br>*GHP PROVIDER #: | *LOCATION: | *PHONE:<br>*FAX: | *FORM COMPLETED BY: |

| | |
|---|---|
| *MEMBER INFORMATION: (Last Name, First Name, MI) | *HEALTH PLAN ID: *BIRTHDATE: |
| ADDRESS:<br>*CURRENT PHONE: | CAREGIVER/ALTERNATE CONTACT:<br>PHONE: |

OTHER INSURANCE INFORMATION: (Workman's Compensation, Auto Insurance, Hospice, other payor, etc, - if applicable)
COMPANY: POLICY NUMBER:

☐ CONSIGNMENT
☐ CHANGE OF CARRIER

DIAGNOSIS INFORMATION:

*DIAGNOSIS CODE: DESCRIPTION:

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REQUESTED INFORMATION:

| | |
|---|---|
| *ORDERING PHYSICIAN: (Last Name, First Name)<br>*PHONE:<br>*FAX: | PRIMARY CARE PHYSICIAN: (If different than ordering physician) (Last Name, First Name) |

REQUESTED EQUIPMENT: (use extra codes sheet as necessary) *ANTICIPATED DELIVERY DATE:

| VENDOR REQUEST | | | **FOR INTERNAL USE ONLY** | | | | |
|---|---|---|---|---|---|---|---|
| *HCPCS/ MODIFIER | *DESCRIPTION | *QTY | AUTHORIZATION # | HCPCS/ MODIFIER | QTY | START DATE | END DATE |
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***Required Information. Incomplete forms will be returned unprocessed.**

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