Geisinger Health Plan

HOME HEALTH SERVICES REQUEST FORM

Phone: (570) 271-5301 Toll Free: 1-800-544-3907 Fax: (570) 271-5507

Request* ◉ Home Health ○ Hospice ○ Infusion Therapy

◉ Initial Therapy ○ Concurrent Therapy

Authorization Number*

Requested Services*

☐ SN ☐ PT ☐ PTA ☐ OT ☐ OTA ☐ ST ☐ HHA ☐ MSW

Member Information*

Member Name:

DOB:

Member ID:

Referral Source *

Referring Provider Name:

Agency Information*

Provider Name:

GHP Provider ID #:

Phone Number

Fax Number:

Requestor's Name :

ICD 10 Codes*

ICD 10 Description*

Start of Care* (enter date)

Tenth Visit Completion Date *

Date of Discharge from Previous Episode of Care*

Resumption of Care Date* (re-admission within 60 days of discharge from previous episode of care with the same or simliar diagnosis OR post discharge from inpatient facility)

Number of Visits Used*

SN	PT	PTA	OT	OTA	ST	HHA	MSW

Lives*

◉ Alone ○ With Caregiver ○ In Facility

Caregiver able to assist*

◉ Yes ○ No

****Please remember to include the most recent visit note from each service for which you are requesting authorization****

***Required Information. Incomplete forms will be returned unprocessed.**

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