Geisinger Health Plan Specialty

Prescription Referral Form

Fax: 1-833-476-0773 | Phone: 1-844-399-0477

www.performspecialty.com

Access. Outcomes. Personalized Care.

GHP PLAN CODE: First Ship To: Patient Physician Need by date:

Patient

Last Name:	First Name:	Gender:	
Date of Birth:	Height: Ft Mt	Weight: Lb Kg	
Address:	City:	State:	Zip:
Phone Home: / Phone Work:	Cell:	Best Time to Call: a.m. p.m.	
Email:	SSN:	Language:	
Allergies:		No Known Drug Allergies (NKDA)	

Provider

Physician Last Name:	Physician First Name:	National Provider Identification (NPI) :	
Practice Name:		State Lic#:	
Address:	City:	State:	Zip:
Drug Enforcement Administration (DEA) # (Optional for non-controls):	Phone:	Fax:	
Key office contact name:	Phone:		

Insurance

Subscriber Name:	Relationship to Patient: Self Other	Prescription Card: Yes No
Primary Insurance:	ID Number:	Phone:
Rx BIN:	Rx PCN:	Rx Group No:
Secondary Insurance:	ID Number:	Phone:
Rx BIN:	Rx PCN:	Rx Group No:

* Please Provide a copy of the insurance card (front and back).

Clinical Information

Diagnosis:	ICD10:	Diagnosis Date:
Current Medications:		
Other Pertinent Past Medical History and Drug Therapy:		
Previously Treated: Yes No If Yes, Please list Therapy:		Dates: mm/dd/yyyy

* Please attach copies of pertinent labs and clinical information in order to assist us in obtaining prior authorization approval.

Prescription Information

MEDICATION	DOSE/STRENGTH	SIG	QUANTITY	REFILLS

Prescription

DEA:	NPI:	License #:	UPIN #:
Patient's Name:			Patient's Date of Birth:

Rx

Drug Name:	Strength:	Dosage From:
Quantity Prescribed:	Number of fills authorized:	

Direction for Use:

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS (STAMPS NOT ACCEPTED)

I certify that the therapy is medically necessary and that the information above is accurate to the best of my knowledge. I authorize PerformSpecialty to act on my behalf as my agent for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient s benefit plan.

Prescriber Signature:	Prescriber Signature:
Dispense as Written (DAW) \ Do Not Substitute Date:	Substitution Permitted / Branded Exchange Date:

For states requiring handwritten expressions of product selection, use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).

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