Geisinger Health Plan

DME AUTHORIZATION CHANGE FORM

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

*DME VENDOR: *GHP PROVIDER #:	*LOCATION: *BRANCH:	*FORM COMPLETED BY:	*PHONE: *EXTENSION: *FAX:

*CHANGE REQUESTED:

Date of Service | Code Change | Change of Equipment | Return/Pick-up | Other

*MEMBER ID:

*MEMBER NAME:

*AUTH NUMBER:

*HCPCS authed:

*HCPCS requested:

***Vendor** specific request and reason:

Adjusted date of delivery:

Equipment change date:

Return or pick-up date:

*Required Information. Incomplete forms will be returned unprocessed.
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.