Geisinger Health Plan

DME RE-CERTIFICATION 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:
*MEMBER INFORMATION: (Last Name, First Name, MI)		*HEALTH PLAN ID:	*BIRTHDATE:
*ADDRESS: *CURRENT PHONE:	*ORDERING PHYSICIAN: (Last Name, First Name) *PHONE: *FAX:		
DIAGNOSIS INFORMATION:			
*DIAGNOSIS CODE:	DESCRIPTION:		
DIAGNOSIS CODE:	DESCRIPTION:		
REQUESTED INFORMATION:			
REQUESTED EQUIPMENT: (use extra codes sheet as necessary)			
VENDOR REQUEST			

*HCPCS/ MODIFIER	*AUTHORIZATION NUMBER	*QTY

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