Geisinger Health Plan

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OUTPATIENT REHABILITATIVE THERAPY SERVICES REQUEST FORM

Phone: (570) 271-5301 Toll Free: 1-800-270-9981 Fax: (570) 271-5302

Request*

Initial Therapy Concurrent Therapy

Therapy Authorization Number: ______________________________

Requested Service*

PT OT ST Chiropractic Spine Bundle

Member Information

Member Name:* ____

DOB:* ____

Member ID:* ____

Referral Source

Referring Provider Name:* ______________________________

Phone Number:* _____________________________________

Fax Number:* ____

Rehab Provider

Provider/Facility Name:* _______________________________

GHP Provider ID or NPI #:* ______________________________________

Phone Number:* ____

Fax Number:* ____

ICD 10 Codes*

____

ICD 10 Description*

Start of Care* (enter date)

Specialty Requests

One (1) Visit Functional Capacity Evaluation

Other Insurance

Workman's Comp Auto

Company: ____________________________ **Contact:** _______________________________

Requestor:* ___________________________ **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.

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