Geisinger Health Plan Medical Management Department **FORM B**
OUTPATIENT REHABILITATIVE THERAPY SERVICES CONCURRENT REVIEW FORM **(Updated Case)**
Phone: (570) 271-5301 Toll Free: 1-800-270-9981 Fax: (570) 271-5302

SECTION 1 **– * Required information. Incomplete forms will be returned unprocessed.**

* Member Information LAST NAME FIRST NAME MI	**GHP Member ID# OR AUTHORIZATION # * Total # of Visits Completed to Date:

SECTION 2

*** Rehabilitative Facility Name (full name)**:
Facilities Health Plan Provider Number OR tax ID #: *Service Requested:
*** Phone:** *** Fax:**
***** Treating Therapist's Name (including discipline): *** PT ☐ OT ☐ ST ☐**

SECTION 3 **– IDENTIFY AREAS OF IMPROVEMENT SINCE THE LAST REQUEST. LIST OBJECTIVE FINDINGS BELOW OR ATTACH RECENT CLINICAL REASSESSMENT INCLUDING FUNCTIONAL/OUTCOME SCORES.**

_____
_____
_____
_____
_____
_____
_____

Functional (Outcome) Score(s):

_____

ANTICIPATED DISCHARGE DATE: _____ CURRENT AUTH END DATE_____

VISIT FREQUENCY?

BARRIERS TO PROGRESS: _____

Treatment interventions being used: _____
Therapist Signature: _____ Date: _____

THE AUTHORIZATION OF ADDITIONAL VISITS MAY BE AFFECTED IF THE CLINICAL INFORMATION SUBMITTED IS NOT CURRENT OR IF FUNCTIONAL SCORES ARE NOT INCLUDED.

Approval verifies appropriateness of a level of care and is not a guarantee of payment.

HPCHS02
rehab_form_B_0314
Dev 10/99, Rev 3/01, 9/06, 2/08, 9/08

HPPNM17
https://spghp/pcoc/Provider Forms/Forms/rehab_form_B_0314.doc
Dev. 03/14