GEISINGER HEALTH PLAN®

Geisinger Health Plan Medical Management Department
OUTPATIENT REHABILITATIVE THERAPY SERVICES CONCURRENT REVIEW FORM
FORM B
(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.

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>**GHP Member ID# OR AUTHORIZATION #</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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<td>* Total # of Visits Completed to Date:</td>
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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.

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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__________________________________________________________________________________________

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.