PHCS network authorization form

This form is to be used by employees and/or dependents who live outside of the Geisinger Health Plan* service area and who do not have access to Geisinger Health Plan preferred providers.

Eligible employees and dependent(s) living outside the Geisinger Health Plan* service area may use the PHCS provider network for services. PHCS is the largest privately owned PPO in the nation. Nearly 15 million people have access to this national network of approximately 450,000 health care providers and over 4,000 facilities. This extensive network can meet your needs, while minimizing out-of-pocket costs.

We encourage you go to www.multiplan.com to search for PHCS providers and/or to call the customer service team at 800-504-0443 to verify provider participation.

If you require PHCS coverage for you and/or your dependent(s), please complete the following:

Group information	
Group name:	Group number:

Employee and dependent information

Legal name (list last name if different than applicant)			Social security number	Date of birth MM/DD/YYYY	Relationship	Require PHCS (out of area)
First	MI	Last			**Employee**	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Social security number	Date of birth MM/DD/YYYY	Relationship	Require PHCS (out of area)
First	MI	Last			☐ Husband ☐ Wife ☐ Domestic partner	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Social security number	Date of birth MM/DD/YYYY	Relationship	Require PHCS (out of area)
First	MI	Last			☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Social security number	Date of birth MM/DD/YYYY	Relationship	Require PHCS (out of area)
First	MI	Last			☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

*Geisinger Health Plan may refer collectively to Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company, unless otherwise noted.

Legal name (list last name if different than applicant)			Social security number	Date of birth MM/DD/YYYY	Relationship	Require PHCS (out of area)
First	MI	Last			☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Social security number	Date of birth MM/DD/YYYY	Relationship	Require PHCS (out of area)
First	MI	Last			☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

**In the space below, please list any disabled child over the age of 26 and/or describe instances where you selected "Other" as your dependent relationship. NOTE: documentation obligating the applicant or the applicant's spouse, if applicable, to provide health care coverage to Dependent(s) will be required. All Dependent(s) must meet eligibility criteria.

Dependent(s) Name	Gender	Disabled	Description of Legal Relationship
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	

PLEASE NOTE: If any of your Dependent(s), for which you are applying, do not live at the address in the Applicant (Employee) Information section, please indicate name(s) and reason(s) why your Dependents(s) do not live at such address, in the space provided below. If your Dependent(s) live with a custodial parent, please provide name of custodial parent.

Employee signature: ______________________________ Date: ______________

Employee name (printed): ______________________________

Employer signature: ______________________________ Date: ______________