Geisinger Health Plan

Outpatient Radiology Notification Form

Fax completed form to (570) 214-0211
All required fields (*) must be completed.
Incomplete forms will be returned unprocessed.

Date of request: (mm/dd/yyyy)	*Member name:	
*Member ID number:	Member DOB:	
Name of person submitting form:	*Phone number of submitter:	Ext:
*Requesting provider: (last name, first name)	*Requesting provider phone:	
	*Requesting provider fax:	
*Servicing provider name: (last name, first name)		
*Requested service:		
*Decision support number (DSN):		
*Appropriateness score:		
*Procedure code(s):		
Diagnosis/symptoms:		
*Diagnosis code(s):		
Diagnosis description:		
*Anticipated date of service/actual date of service: (mm/dd/yyyy)		

Failure to use the National Decision Support system tool and provide notification to GHP prior to service(s) being rendered will result in unpaid claims.