GEISINGER HEALTH PLAN®

DME INITIAL PRECERTIFICATION FORM

PHONE: 866-248-1972
LOCAL: 570-271-7127
FAX: 570-271-7171

*DME VENDOR: *GHP PROVIDER #:	*LOCATION:	*PHONE: *FAX:	*FORM COMPLETED BY:
*MEMBER INFORMATION: (Last Name, First Name, MI)		*HEALTH PLAN ID:	*BIRTHDATE:
ADDRESS: *CURRENT PHONE:		CAREGIVER/ALTERNATE CONTACT: PHONE:	

OTHER INSURANCE INFORMATION: (Workman's Compensation, Auto Insurance, Hospice, other payor, etc, - if applicable)
COMPANY: POLICY NUMBER:

☐ CONSIGNMENT
☐ CHANGE OF CARRIER

DIAGNOSIS INFORMATION:

*ICD-9 CODE: DESCRIPTION:

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REQUESTED INFORMATION:

*ORDERING PHYSICIAN: (Last Name, First Name) *PHONE:

*FAX:

PRIMARY CARE PHYSICIAN: (If different than ordering physician) (Last Name, First Name)

REQUESTED EQUIPMENT: (use extra codes sheet as necessary)

*ANTICIPATED DELIVERY DATE:

VENDOR REQUEST			FOR INTERNAL USE ONLY				
*HCPCS/ MODIFIER	*DESCRIPTION	*QTY	AUTHORIZATION #	HCPCS/ MODIFIER	QTY	START DATE	END 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.