Geisinger Health Plan Outpatient Rehabilitative Therapy Services Network **FORM A**
OUTPATIENT REHABILITATIVE THERAPY SERVICES REFERRAL FORM **(New Case)**
Phone: (570) 271-5301 Toll Free: 1-800-270-9981 Fax: (570) 271-5302

SECTION 1 **– (completed and fax upon initial visit) *Required information. Incomplete forms will be returned unprocessed.**

Member Information	**Referral Source**	***Rehab Provider Facility Name**
***Last Name, First Name, MI:**	Referring Physician	Location:
	*First Name, Last Name	* Tax ID number or GHP Provider #
*DOB:	***Phone:**	***Phone #:**
Address:	***Fax:**	***Fax #:**
***GHP ID#:**	***Service Requested** PT ☐ OT ☐ ST ☐	*Site of Service: O/P Clinic ☐ SNF ☐ Hospital ☐ CORF ☐ Assisted Living Facility ☐

OTHER INSURANCE INFORMATION: please circle: Workman's Compensation , Auto Insurance, Other
Company: Date of Accident:

Contact Person: Phone Number:

DIAGNOSIS INFORMATION- requests must have a diagnosis listed below

*DIAGNOSIS CODE: *DESCRIPTION:

RELATEAD SURGICAL PROCEDURES: (Include Dates)

SECTION 2 **–**

INDICATE BELOW IF THIS REQUEST IS FOR ANY OF THE FOLLOWING:

☐ FCE, ANTICIPATED DATE OF EXAM _____

☐ ONE VISIT ONLY, DATE SCHEDULED _____

☐ POST OP SURGICAL CARE, LIST ABOVE

☐ RELATED TO WORK COMP OR MVA, LIST ABOVE

☐ VIDEO FLUOROSCOPY STUDY
(NOTE, EFFECTIVE Sept 2012, VFSS//MBS studies do not require authorization)

PLEASE INDICATE IF ANY OF THE FOLLOWING MODALITIES WILL BE USED:

☐ LASER
☐ LIGHT THERAPY
☐ ANODYNE/NEAR INFRARED
☐ AQUATIC
☐ WORK CONDITIONING
☐ WORK HARDENING
☐ METRONOME
☐ BIOFEEDBACK
☐ SENSORY INTEGRATION
☐ E. STIM FOR BELL'S PALSY

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Therapist Signature: _____ Date: _____