Geisinger Health Plan **Inpatient Planned Precertification Form**

WE ONLY PRECERT WITHIN 30 DAYS OF THE PLANNED PROCEDURE

Please fax completed form to 570-271-5534.

PLEASE PRINT:

Requestor's Name:	
Requestor's Number:	
Requestor's Fax #:	
Member Name:	
Member ID#:	
Member Date of Birth:	
Date of Admission:	
Physician's Name:	
Name of facility completing procedure:	
Diagnosis:	
Diagnosis Code(s):	
Procedure:	
Procedure code(s):	
Clinical Trial:	YES ☐ NO ☐ N/A ☐
Other Insurance:	
Additional information:	

Incomplete forms will be returned unprocessed.
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.
Rev: 05/2018