Geisinger Health Plan

Inpatient Admission Review
Please Fax to 570-271-5534

Date/Time:		**Auth #:**	
Member Name:		**ID #:**	
DOB:		**COB:** Yes or No	
Admitting Facility:		**Admitting Diagnosis:**	
Date of Admission:		**Admitting Physician:**	
Reviewer's Name:		**Reviewer's Phone #:**	
Admitted from…. (Ex: ER, PCP, SPU, Clinic)		**Admitted to… (Ex: ICU, CCU, Tele, Med-Surg, Peds)**	
Request being made for….(Ex: Admission, Observation or Extended Observation)			

Past Medical History: Check all that apply.							
Heart Failure		COPD		Diabetes		CVA	
Anemia		Pneumonia		HTN		MI	
CAD		PVD		Kidney Disease		Liver Disease	
Lung Cancer		Skin Cancer		Breast Cancer		Colon Cancer	
UTI's		Low Back Pain		Syncope		GERD	
Hyperlipidemia		Osteoporosis		Dementia		Depression	
Falls		Tobacco Use		Alcohol Use		Drug Use	
Additional Past Medical History and Surgical History:							

Story of Event/Admission:
Vitals, EKG:

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Abnormal Labs including Cultures:					
WBC		Glucose		Trop	
H/H		K		CK	
PT/INR		Na		MB	
PTT		BUN		Cultures	
Plates		CR		ABG's	
BNP		GFR			
Amylase		Ca			
Lipase		Mag			

Imaging including CXR, CT, MRI/MRA:

Orders/Plans/Management:

Comments/What is reason for admission?

Anticipated Length of Stay:	

Discharge Plans/Needs:

*Required Information. Incomplete forms will be returned unprocessed.
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.