Geisinger

Health Plan

Outpatient Prior Authorization Form

Please fax completed form to (570) 214-3572.
All required fields (*) must be completed.
Incomplete forms will be returned unprocessed.

Still faxing? If so, you may be missing out on timesaving benefits, including automatic approvals and guided submission only available when using the Cohere portal to manage authorizations. Registration only takes a few minutes and unlocks access for all users at your practice organization.

Visit www.coherehealth.com/register to begin.

Date of Request: (mm/dd/yyyy)	*Member Name:	
Member Medical Record#:	*Member ID:	*Member DOB:
*Contact Person:	*Contact Phone:	Ext.
*Requesting Provider (Last Name, First Name):	*Requesting Provider NPI:	*Requesting Provider Phone:
	*Requesting Provider TIN:	*Requesting Provider Fax:
*Servicing Provider (Last Name, First Name):	*Servicing Provider NPI:	*Servicing Provider Phone:
	*Servicing Provider TIN:	*Servicing Provider Fax:
*Facility/Location of Service:	* Facility/Location of Service NPI:	*Facility/Location of Service Phone:
	*Facility/Location of Service TIN:	*Facility/Location of Service Fax:
Facility/Location Address		
Speciality Vendor Name	Speciality Vendor Phone	
	Speciality Vendor Fax	
*Requested Service		
* Anticipated Date of Service/Actual Date of Service: (mm/dd/yyyy)		
Diagnosis		
*Diagnosis Code(s):		
Diagnosis Description		
*Procedure Code(s)		
*Submitter Name:	*Submitter Phone:	
Submitter Email:	Submitter Fax:	

In order to process this request supporting documentation must be attached for review. Precertification authorization verifies medical necessity criteria have been met and is nota guarantee of payment.