Geisinger Health Plan

Update for Inpatient Review

Please Fax to 570-271-5534

Date of Review:		**Auth #:**	
Member Name:		**ID #:**	
Date of Birth:		**Admitting Diagnosis:**	
Admitting Facility:		**Admitting Physician:**	
Reviewer's Name:		**Reviewer's Phone #:**	

Vitals:					
Abnormal Labs Including Cultures:					
WBC		Glucose		Trop	
H/H		K		CK/MB	
PT/INR		Na		BNP	
PTT		BUN/CR		Amylase	
Plates		Ca		Lipase	
Mag		GFR		Cultures	
Imaging including CXR, CT, MRI/MRA:					
Orders/Plans/Management:					
Anticipated Length of Stay:					
Discharge Plans/Needs:					
Needed Outpatient Referrals:					

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