Geisinger Health Plan

Discharge Concurrent Review Form

Fax completed form to 570-953-0368 ATTN: SNF Case Managers

Member Name:	
Member DOB:	
Authorization #:	
Discharge Plan:	
Home Care Services/Needs:	
Education (Family and/or member):	
Home Evaluation:	
Durable Medical Equipment Needed:	
Planned Target Discharge Date, if known:	
Comments:	

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AFTER MEMBER is discharged from building please complete the following.

LCD:	
Discharge Date:	
(If discharge is to HOSPITAL, please note the date the member LEFT the SNF):	
Discharge disposition (Use Codes Below)**:**	
If discharge to PCH, ALF, or another SNF, please state the name of facility:	

DISCHARGE CODES FOR ABOVE:

01 – Home/Personal Care Home/Assisted Living Facility
02 – Hospital
03 – Another SNF, Skilled Level
04 – ICF (Custodial level of care at the nursing home)
06 – Home with Home Health Services
07 – AMA (Left Against Medical Advice)
20 - Expired

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