Dialysis Authorization

Patient name: _____

ID number: _____ Date of birth: _____

Home phone: _____ Cell phone: _____

Member address: _____

_____

Dialysis center: _____

Tax ID: _____ Fax: _____

Address: _____

Social worker: _____ Phone: _____

Nephrologist: _____

Phone: _____

Diagnosis code(s): _____

Date of first dialysis: _____

Date of first dialysis at this facility: _____

Type of dialysis (hemodialysis, peritoneal, other – please define): _____

_____

Contact name: _____ Phone: _____ Ext: _____

IMPORTANT: GEHA cannot complete this authorization without the first original date of dialysis, diagnosis code(s) and the first date at your facility.

****Inpatient acute dialysis does not require prior authorization****

*****Outpatient Acute dialysis requires review*****

Please fax completed form to 816.257.3515 or 816.257.3255

Or mail documents to:

GEHA
Care Management Department
P.O. Box 21542
Eagan MN 55121

All benefit payments are subject to review for any applicable deductibles, coinsurance, maximums, medical necessity and patient eligibility on the date that the service is provided or the supply delivered.