



The Benefits of Better Health

### 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.**

**\*\*Acute dialysis does not require prior authorization\*\***

**Please fax completed form to 816.257.3515 or 816.257.3255.**

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.