GEHA
The Benefits of Better Health

Experimental/Investigational and Cosmetic Authorization

Date of request: _____ Anticipated service date: _____

Patient name: _____ _____ _____
[First name] [Middle initial] [Last name]

ID number: _____ Date of birth: _____

Patient phone: _____

Member address: _____

_____

Physician information

Provider name: _____ _____ _____
[First name] [Middle initial] [Last name]

Tax ID number: _____

Office street address: _____

City: _____ State: _____ Zip: _____

Contact person: _____ _____ _____
[First name] [Middle initial] [Last name]

Phone number: _____ Ext.: _____ Fax: _____

Primary diagnosis ICD-10: _____ ICD-10 codes: _____ _____ _____

List all proposed CPT/procedure codes: _____

_____

IMPORTANT: In addition to this completed form, submit:

1. Current patient history and physical;
2. Clinical/office notes;
3. A letter of medical necessity from provider; and
4. Medical test that proves the need for the surgery.

Mail completed form and supporting documents to: GEHA
P.O. Box 4665
Independence, MO 64051

Photos can be emailed to our secure email, please call for the email address.

GEHA fax number: 816.257.3255 Questions? Call GEHA at 800.821.6136 ext. 3100

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.