Experimental/Investigational, Cosmetic or Reconstruction Authorization

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Purpose of this form

You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

Experimental/ Investigational

In addition to this form, submit:

- Complete description of any unlisted surgery code
- Pre-op consult and plan of treatment including number of visits
- For post procedure submissions, include operative and/or procedure reports,
- Medical test that proves the need for the surgery

How to complete the form

We recommend reviewing **GEHA's coverage policy for Cosmetic and Reconstruction Treatment** before completing this form. You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need help, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form

Our reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health, or ability to regain maximum function.

GEHA®

Experimental/Investigational, Cosmetic or Reconstruction Authorization

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Date of request: _____ Anticipated service date: _____

Patient name: _____ Phone: _____

Preferred pronouns: _____ (optional)

ID number: _____ Date of birth: _____

Member address: _____

_____

Physician: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext. _____ Fax: _____

Facility: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext. _____ Fax: _____

DX: _____ ICD-10 code: _____

Requested CPT codes: _____

Please specify for each code if Bilateral or Single: _____

Place of service: ☐ Inpatient ☐ Outpatient

Note: Inpatient stays require a separate authorization from the surgery.

Experimental/Investigational, Cosmetic or Reconstruction Authorization

IMPORTANT: In addition to this form, submit:

- Complete description of any unlisted surgery code
- Current history and physical
- Pre-op consult and plan of treatment including number of visits
- For post procedure submissions, include operative and/or procedure reports,
- Clinical studies/tests addressing the physical/physiologic abnormality
- confirming its presence and degree to which it causes impairment
- Color photos, where applicable with date stamp (send to **caremanagementsurgery@geha.com**)

Submit completed form and supporting documents to:

GEHA
P.O. Box 21542
Eagan, MN 55121

Fax: 816.257.3255 or
Color photos to secure email:
caremanagementsurgery@geha.com

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.