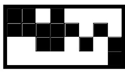
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GEHA Therapy Fax Request Form

PLEASE USE THIS FORM FOR ALL GEHA MEMBERS

Fax Date: ____________ # of Pages Faxed: _______ Please fax to OrthoNet at: (877) 304-4398

THERAPY PROVIDER INFORMATION

Facility Name

Street Address

City

State

Zip

Telephone Number ( ) -

Fax Number ( ) -

GEHA Provider ID Number

And/Or:

National Provider Identifier (NPI)

O **Facility NPI Number**

O **Individual NPI Number**

And/Or:

Provider Tax ID Number

O **Facility Tax ID Number**

O **Individual Tax ID Number**

REQUEST INFORMATION

Request for:

O Therapy Visits Pre-Certification

O Other Procedure: ___________________________

Is this request for post-operative therapy visits?

O Yes O No

Diagnosis (ICD-9 Format)

1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9
0	0	0	0	0

Service Type

O Physical Therapy

O Occupational Therapy

O Speech Therapy

Initial Evaluation Date

/ /

Month Day Year

Requested # of Visits

PATIENT INFORMATION

First Name

Last Name

Date of Birth

/ /

Month Day Year

GEHA Member ID Number

Instructions:

1. Use this form as a Fax Cover Sheet and send all supporting clinical data with this request.
2. Please ensure that this form is a DIRECT COPY from the MASTER.
3. Please PRINT, in black ink, one character per box for ALL requested information and completely fill in each circle that represents the corresponding NUMBER entry where applicable.
4. For assistance in completing this form, please call OrthoNet Provider Services Toll Free at (877) 304-4399.

For Internal Office Use Only

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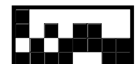

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Shade Circles Like This -----> ● Not Like This -----> ⊗ ⌀