GEISINGER HEALTH PLAN

Geisinger

First Health Network authorization form

The First Health® Network provides out-of-area coverage to employees and/or dependents who live outside the Geisinger Health Plan* (GHP) service area and who do not have access to GHP preferred providers.

Eligible employees and dependent(s) living outside the Geisinger Health Plan service area may use the First Health provider network with all covered services paid in-network. With First Health, you get a lot: more than 96% of all U.S. hospitals, over 800,000 providers and 125,000+ ancillary providers across the country.

First Health is available to eligible members with PPO plans and dependents with HMO plans only.

Here's how to find First Health providers online:

1. Go to myfirsthealth.com and click "Start Now."
2. Pick a provider type.
3. Choose to search by zip code or state (to include more search options, click "Show more options." You can search by provider name, specialty or condition).
4. Click "Search now."

Or, you can call our customer care team at 800-447-4000 to verify provider participation.

If you need out-of-area coverage for you and/or your dependent(s), complete the forms on the following pages.

*Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated healthcare delivery and coverage organization.

Group information

Group name:	Group number:

Employee and dependent information

Legal name (list last name if different than applicant)			Social security number	Employee ID	Relationship	Require out-of-area
First	MI	Last			Employee	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Does the dependent reside outside GHP service area?		Relationship	Require out-of-area
First	MI	Last	Yes, as of __/____/_____ (MM/DD/YYYY)	☐ No	☐ Husband ☐ Wife ☐ Domestic partner	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Does the dependent reside outside GHP service area?		Relationship	Require out-of-area
First	MI	Last	Yes, as of __/____/_____ (MM/DD/YYYY)	☐ No	☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Does the dependent reside outside GHP service area?		Relationship	Require out-of-area
First	MI	Last	Yes, as of __/___/____ (MM/DD/YYYY)	☐ No	☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Does the dependent reside outside GHP service area?		Relationship	Require out-of-area
First	MI	Last	Yes, as of __/____/_____ (MM/DD/YYYY)	☐ No	☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

Legal name (list last name if different than applicant)			Does the dependent reside outside GHP service area?		Relationship	Require out-of-area
First	MI	Last	Yes, as of __/____/_____ (MM/DD/YYYY)	☐ No	☐ Son ☐ Daughter ☐ Other**	☐ Yes ☐ No
Address			City		State	Zip

**In the space below, list any disabled child over the age of 26 and/or describe instances where you selected "Other" as your dependent relationship. Note: Documentation obligating the applicant or the applicant's spouse, if applicable, to provide healthcare coverage to dependent(s) will be required. All dependent(s) must meet eligibility criteria.

Dependent(s) name	Gender	Disabled	Description of legal relationship
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	
	☐ Female ☐ Male	☐ Yes ☐ No	

Note: If any dependent(s) for which you are applying do not live at the address in the applicant (employee) information section, indicate name(s) and reason(s) why they do not live at that address in the space provided below. If your dependent(s) live with a custodial parent, provide name of custodial parent.

Employee signature: Date:

Employee name (printed):

Return this form with the appropriate enrollment document (subscriber application or change form) to your dedicated enrollment specialist.

This form is not required if submitting enrollments or changes via the employer portal. To register for the employer portal, contact your broker or GHP service specialist.