PREAUTHORIZATION TREATMENT REQUEST FORM

Gold Coast Health Plan℠ A Public Entity

☐ URGENT (Three business days) ☐ Routine ☐ RETRO

FAX TO: (855) 883-1552 PHONE: (888) 301-1228 www.goldcoasthealthplan.org

IN ORDER TO PROCESS YOUR REQUEST, THIS FORM MUST BE COMPLETED AND LEGIBLE

PROVIDER: Authorization Does Not Guarantee Payment. Eligibility Must Be Verified At Time Services Are Rendered.

Patient Name: _____ Date: _____
Last First

Mailing Address: _____ City: _____ Zip: _____

CIN Number: _____ ☐M ☐F D.O.B. _____ Age: _____

Name of PCP: _____ Location: _____

Ordering Provider: ☐ In-Network ☐ Out-of-Network ☐ Out-of Area	*Provider Rendering Service (Physician, Facility, Vendor):* ☐ In-Network ☐ Out-of-Network ☐ Out-of-Area
Provider Name: _____	Provider Name: _____
Specialty: _____	Specialty: _____
TIN: _____ NPI: _____	TIN: _____ NPI: _____
Address: _____	Address: _____
City: _____ St: _____ Zip: _____	City: _____ St: _____ Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Office Contact: _____	Office Contact: _____

AUTHORIZATION REQUEST

☐ Outpatient Facility ☐ DME ☐ Hospice ☐ Interventional Pain Management ☐ Surgical
☐ Inpatient Facility ☐ Home Health ☐ Rehab Services ☐ CBAS: ☐ *New* or ☐ *Re-Eval*
☐ SNF ☐ Home Infusion (PT, OT, ST) ☐ Radiology-Imaging Services
Estimated Length of Stay (days): _____ ☐ CCS ☐ Other

***** Referring Provider's Order must be submitted*****

Date(s) of Services: _____ Retro Date(s) of Service: _____

List ALL procedures requested along with appropriate CPT code

Diagnosis: _____ ICD-9: _____ ICD-10: _____

CPT/HCPCS Code(s):	Requested Procedure(s):	Quantity:	CPT/HCPCS Code(s):	Requested Procedure(s):	Quantity:

Pertinent History (Submit relevant Medical Records, Test Results, X-rays, etc.***)***