Gold Coast Health Plan[SM]
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

PREAUTHORIZATION TREATMENT REQUEST FORM

☐ **URGENT (72 hours)** ☐ **Routine** ☐ **RETRO**

FAX TO: 1-855-883-1552 PHONE: 1-888-301-1228 www.goldcoasthealthplan.org

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: ______________________ ☐ Male ☐ Female Date of Birth: __________ Age: ______

Name of PCP: ______________________ Location: ______________________

ORDERING PROVIDER:
☐ In-Network ☐ Out-of-Network ☐ Out-of-Area

Provider Name: ______________________
Specialty: ______________________
TIN: ______________ NPI: ______________
Address: ______________________
City: ______________ State: ______ Zip: ________
Phone: ______________ Fax: ______________
Office Contact: ______________________

PROVIDER RENDERING SERVICE (Physician, Facility, Vendor):
☐ In-Network ☐ Out-of-Network ☐ Out-of-Area

Provider Name: ______________________
Specialty: ______________________
TIN: ______________ NPI: ______________
Address: ______________________
City: ______________ State: ______ Zip: ________
Phone: ______________ Fax: ______________
Office Contact: ______________________

AUTHORIZATION REQUEST

☐ Outpatient Facility
☐ Inpatient Facility
☐ SNF
☐ DME Rental (RR)
☐ Home Health
☐ Home Infusion (PT, OT, ST)
☐ DME Purchase (NU)
☐ Rehab Services
☐ Radiology Imaging Services
☐ Hospice
☐ CBAS: ☐ *new or* ☐ *Re-Eval*
☐ CCS
☐ Interventional Pain Management
☐ Surgical
☐ Other

Estimated Length of Stay (days): ______________

REFERRING PROVIDER'S ORDER MUST BE SUBMITTED

Date(s) of Service: ______________________ Retro Date(s) of Service: ______________________

List ALL procedures requested along with appropriate CPT code

Diagnosis: ______________________ 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.)