Gold Coast Health Plan℠
A Public Entity

Direct Referral Authorization Form

Instructions: Direct Referrals to Specialists may be made using the following methods:
This form can be download from the GCHP website so that a copy can be kept in the PCP record. One can be given to the member to take to the referring physician's office.
If this is an Out of Network referral, the Preauthorization Treatment Request Form must accompany this form.

Electronic Requests: www.goldcoasthealthplan.org
Verbal Requests: Call center (888) 301-1228
Written Requests: Gold Coast Health Plan, P.O. Box 9153, Oxnard, CA 93031.
You may also fax to (888) 310-3660.

PCP INFORMATION: _____
PCP Group Name:
Physician Name:
PCP Office Address:
City: State: Zip Code:
NPI #: Office Phone:

MEMBER INFORMATION: _____
Member Name: Member ID #:
Date of Birth: Age:
Primary Address:
City: State: Zip Code:
Primary Phone: Secondary Phone:
Confirmed / Suspected Dx: Duration of Symptoms:

REFERRAL SPECIALIST INFORMATION: _____
Group Name:
Physician Name (if part of group):
Address:
City: State: Zip Code:
NPI #: Office Phone:

DESCRIPTION OF AUTHORIZATION LIMITATION: _____
- ☐ Consultation only
- ☐ Consultation and Treat

(Note: If a prior authorization is required for the specific treatment indicated, a Preauthorization Request Form submission will be required prior to treatment.)

AUTHORIZATION EFFECTIVE DATES: _____

Authorization is valid from _____ through _____ (dates).

PCP Signature _____ Date issued _____