CT/MRI/MRA/PET CLINICAL PRE-AUTHORIZATION ADDENDUM

FAX (855) 883-1552

www.goldcoasthealthplan.org

Date:___________________

THIS FORM MUST BE COMPLETED AND LEGIBLE

Patient Name:_____________________________________

DOB:____

CIN:____

____

Referring Physician:________________________________

Address:____

Person Completing Form:_____________________________

Phone:_____________________ Fax:___________________

*Is the condition a result of a motor vehicle accident?	*Is the condition a result of a work-related incident?
☐ Yes ☐ No	☐ Yes ☐ No

Imaging Facility Name:______________________________

Site Address:_______________________________________

City:________________________ ST:________ Zip:_______

Site Phone:____

Requested CPT/Exam:_______________________________

ICD-9:_________________/ICD-10:___________________

Diagnosis:____

Site Fax:____

Symptoms and Complaints (Include duration):

____

____

Relevant Physical Exam Findings:

____

____

Relevant Neurological Exam Findings:

____

____

Previous Treatment Measures (Include PT/Medications/Prior Imaging):

____

____

Other Relevant Information:

____

____

____

____

Physician's Signature:____ Date:______________________________

MUST BE SUBMITTED WITH PRE-AUTHORIZATION TREATMENT REQUEST FORM

Revised July 30, 2015