Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

DIRECT REFERRAL AUTHORIZATION FORM

Instructions: Direct referrals to In-Network/In-Area specialists do not require preauthorization. After completing this form, the referring provider can send a copy to the specialist and schedule the member for his/her specialist appointment.

**** If this is an Out-of-Network/Out-of-Area referral, please utilize the Preauthorization Treatment Request Form ****

PATIENT INFORMATION

Patient Name: _____ _____ **Date:** _____
Last First

Mailing Address: _____ **City:** _____ **Zip:** _____

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

Name of PCP: _____ **Facility:** _____

Address: _____ **Phone:** _____

ORDERING PROVIDER ☐ IN NETWORK ☐ OUT OF AREA

Provider Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **Speciality:** _____

City: _____ **State:** _____ **Zip:** _____ **TIN:** _____ **NPI:** _____

Office Contact: _____

REFERRAL SPECIALIST INFORMATION

Provider Name: _____ **Phone:** _____ **Fax:** _____

Address: _____ **Speciality:** _____

City: _____ **State:** _____ **Zip:** _____ **TIN:** _____ **NPI:** _____

Office Contact: _____

Description Of Authorization Limitation: _____

☐ Consultation Only ☐ Consultation and Treatment

(Note: If a preauthorization 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).

Provider Signature: _____ Date Issued: _____

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