Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

COMMUNITY SUPPORTS (CS)
MEDICALLY SUPPORTIVE FOOD AUTHORIZATION REQUEST FORM

☐ **Initial Request** ☐ **Reauthorization** ☐ **Urgent (72 hours)** ☐ **Routine** ☐ **Retroactive**

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

PROVIDER INFORMATION

Referring (Ordering) Provider	Servicing CS Provider ☐ Same as Referring (Ordering) Provider
Name: ______	Name: ______
Specialty: ______	Specialty: ______
NPI: ______ TIN: ______	NPI: ______ TIN: ______
Address: ______	Address: ______
City: ______ State: ______ Zip: ______	City: ______ State: ______ Zip: ______
Phone: ______ Fax: ______	Phone: ______ Fax: ______
Office Contact: ______	Office Contact: ______

MEMBER INFORMATION

Last Name: ______ First Name: ______

Mailing Address: ______ City: ______ Zip: ______ *(Required)*

Medi-Cal ID: ______ *(Required)* Phone: ______ Birth Date: ______ *(Required)* Age: ______

Name of PCP: ______ Location: ______

Members already receiving similar services through other local, state, and federal programs cannot also receive GCHP Community Supports at the same time.

Medically Supportive Food cannot be used to only address food insecurity; members must meet eligibility criteria.

Diagnosis: ______ **ICD-10**: ______

Date of Service	HCPCS Code	Modifier	Quantity
Date of Service: ______	HCPCS Code: ______	Modifier: ______	Quantity: ______
Date of Service: ______	HCPCS Code: ______	Modifier: ______	Quantity: ______
Date of Service: ______	HCPCS Code: ______	Modifier: ______	Quantity: ______

☐ Documents to submit with request:	☐ Referral form (if applicable)

ELIGIBILITY CRITERIA

☐ Members whose health could benefit from short-term meals tailored to their needs based on identified chronic conditions.