Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

PRIOR AUTHORIZATION TREATMENT REQUEST FORM

☐ URGENT (72 hours) ☐ ROUTINE ☐ RETRO

FAX: 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:	Rendering Provider:	Facility / Vendor:
☐ In-Network ☐ Out-of-Network ☐ Out-of-Area	☐ In-Network ☐ Out-of-Network ☐ Out-of-Area	☐ In-Network ☐ Out-of-Network ☐ Out-of-Area
Name:	Name:	Name:
Specialty:	Specialty:	Specialty:
NPI:	NPI:	NPI:
TIN:	TIN:	TIN:
Address:	Address:	Address:
City:	City:	City:
State: Zip:	State: Zip:	State: Zip:
Phone: Fax:	Phone: Fax:	Phone: Fax:
Office Contact:	Office Contact:	Office Contact:

AUTHORIZATION REQUEST

☐ Outpatient Facility ☐ DME Rental (RR) ☐ DME Purchase (NU) ☐ Hospice ☐ Interventional Pain Management
☐ Inpatient Facility ☐ Home Health ☐ Rehab Services (PT, OT, ST) ☐ Surgical ☐ Other
☐ SNF ☐ Home Infusion ☐ Radiology Imaging Services ☐ CCS

Estimated Length of Stay (days): _____

REASON FOR OUT-OF-NETWORK REQUEST

☐ Member's Preference ☐ Provider Not Accepting New Patients ☐ Provider Not Available In-Network
☐ Specialized Procedure / Area of Expertise ☐ Timely Access to Provider ☐ Other: _____

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(s)

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.)