Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

MEDICALLY TAILORED MEALS 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 CalAIM Community Supports at the same time.

Medically Tailored Meals 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: _____

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

ELIGIBILITY CRITERIA

☐ Diagnosis of Congestive Heart Failure (CHF) AND

☐ Individuals being discharged from the hospital or SNF within 30 days