

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				
		Zip:		
CIN Number:				
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:		
IPI: NPI:		NPI:		
TIN:			TIN:	
Address:	Address:		Address:	
City:	City:		City:	
State: Zip:			State: Zip:	
Phone: Fax:	Phone: Fax: Office Contact:		Phone: Fax:	
Office Contact:			Office Contact.	
AUTHORIZATION REQUEST				
☐ Outpatient Facility ☐ DME Rental (RR) ☐ Inpatient Facility ☐ Home Health ☐ SNF ☐ Home Infusion	□ DME Purchase (NU) □ Hospice □ Interventional Pain Management □ Rehab Services (PT, OT, ST) □ Surgical □ Orthotics / Prosthetics □ Radiology Imaging Services □ CCS □ Other			
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 Proce	dure(s) Quantity CPT/HC	PCS Code(s)	Requested Procedure(s)	Quantity
PERTINENT HISTORY (SUBMIT RELEVANT MEDICAL RECORDS, TEST RESULTS, X-RAYS, ETC.)				