Gold Coast Health Plan℠
A Public Entity

# URGENT CARE CENTER TREATMENT AUTHORIZATION REQUEST (TAR) FORM

During Regular PCP Office Hours: 8:30 am to 5:30 pm, Monday through Friday

Date: _____

Rendering Provider/Facility:_____

Patient Name _____ Gender ☐ M ☐ F

Date of Birth: _____ CIN # _____

Time checked in _____ ☐ AM ☐ PM

Chief Complaint

_____

_____

_____

Name of PCP _____ ☐ M.D. ☐ D.O.

Contacted at _____ ☐ AM ☐ PM

☐ PCP not available

☐ PCP requested that patient be sent to PCP office

☐ PCP authorized patient to be evaluated and treated

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