Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

PREAUTHORIZATION TREATMENT REQUEST FORM

☐ URGENT (72 hours) ☐ Routine ☐ RETRO

FAX TO: 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:

☐ In-Network ☐ Out-of-Network ☐ Out-of-Area

Provider Name: _____

Specialty: _____

TIN: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

PROVIDER RENDERING SERVICE (Physician, Facility, Vendor):

☐ In-Network ☐ Out-of-Network ☐ Out-of-Area

Provider Name: _____

Specialty: _____

TIN: _____ NPI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Office Contact: _____

AUTHORIZATION REQUEST

☐ Outpatient Facility ☐ DME Rental (RR) ☐ DME Purchase (NU) ☐ Hospice ☐ Interventional Pain Management
☐ Inpatient Facility ☐ Home Health ☐ Rehab Services ☐ CBAS: ☐ *new or* ☐ *Re-Eval* ☐ Surgical
☐ SNF ☐ Home Infusion (PT, OT, ST) ☐ Radiology Imaging Services ☐ CCS ☐ Other

Estimated Length of Stay (days): _____

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

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.)