CT/MRI/MRA/PET CLINICAL PRE-AUTHORIZATION ADDENDUM

FAX (855) 883-1552

www.goldcoasthealthplan.org

Date:_____

*****THIS FORM MUST BE COMPLETED AND LEGIBLE*****

Patient Name:_____ **Referring Physician:**_____

DOB:_____ **Address:**_____

CIN:_____ **Person Completing Form:**_____

_____ **Phone:**_____ **Fax:**_____

*Is the condition a result of a motor vehicle accident?	*Is the condition a result of a work-related incident?
☐ Yes ☐ No	☐ Yes ☐ No

Imaging Facility Name:_____ **Requested CPT/Exam:**_____

Site Address:_____ **ICD-9:**_____/**ICD-10:**_____

City:_____ **ST:**_____ **Zip:**_____ **Diagnosis:**_____

Site Phone:_____ **Site Fax:**_____

Symptoms and Complaints (Include duration):

_____

_____

Relevant Physical Exam Findings:

_____

_____

Relevant Neurological Exam Findings:

_____

_____

Previous Treatment Measures (Include PT/Medications/Prior Imaging):

_____

_____

Other Relevant Information:

_____

_____

_____

_____

Physician's Signature:_____ **Date:**_____

*****MUST BE SUBMITTED WITH PRE-AUTHORIZATION TREATMENT REQUEST FORM*****