GOLD KIDNEY HEALTH PLAN

Authorization Request Form
Fax Request to: 1-866-515-7869

Instructions: Before submitting this request, please verify that the service code(s) you are requesting require prior authorization (PA).

Gold Kidney Health Plan requires providers to obtain prior authorization for certain services before they are rendered. Claims submitted without required authorization may be denied and become the provider's financial responsibility.

By submitting this form, you certify that all information provided is true, complete, and accurate.

All fields must be completed for processing.

SECTION 1. PATIENT INFORMATION

Last Name	First Name	MI

Date of Birth (mm/dd/yyyy)	Member ID	Phone Number

SECTION 2. REQUESTING PROVIDER INFORMATION

Provider Name	Tax ID Number

NPI	Phone Number	Fax Number

Provider Address	City	State	ZIP Code

Primary Contact Person (for additional information)

Phone Number (including ext.)	Fax Number

SECTION 3. SERVICING PROVIDER / FACILITY INFORMATION
(If different from requesting provider)

Provider / Facility / DME Name	Tax ID Number

NPI	Phone Number	Fax Number

Provider Address	City	State	ZIP Code

Primary Contact Person (for additional information)

Phone Number (including ext.)	Fax Number

SECTION 4. SERVICE REQUEST DETAILS

Type of Request (select only one option):

☐ **Pre-Service**

☐ **Standard** ☐ **Expedited***

☐ **Concurrent**

☐ **Post-Service**

☐ **Part B Drug** (Buy and Bill)

☐ **Standard** ☐ **Expedited***

****Expedited is defined as:** when the member or his/her physician believes that waiting for a decision under the standard time frame could place the patient's life, health, or ability to regain maximum function in serious jeopardy.*

Type of Service (select applicable option):

☐ **Emergency Admission** (Medical, Surgical, Behavioral, or Psychiatric)

☐ **Elective Admission** (Medical, Surgical, Behavioral, or Psychiatric)

☐ **Observation Stay**

☐ **LTACH / Inpatient Rehabilitation** (IPR)

☐ **Skilled Nursing Facility** (SNF)

☐ **Outpatient Diagnostic** (Labs, Imaging, Cardiac, Pulmonary, Sleep Study, Mammogram, DEXA etc.)

☐ **Outpatient Surgical** (Endoscopy, Colonoscopy, Cataract removal, Hernia repair, Arthroscopy, Orthopedic surgery etc.)

☐ **Outpatient Medical** (Office visits, Infusion/Injections, Chemotherapy, Radiation Therapy, Dialysis, Wound Care, Physical/Occupational/Speech Therapy etc.)

☐ **Outpatient Behavioral / Psychiatric** (Individual or group therapy, psychiatric evaluation, substance use treatment, partial hospitalization, intensive outpatient program etc.)

☐ **Home Health Services** (Services provided in the home by a licensed Home Health Agency)

☐ **Durable Medical Equipment** (DME) **/ Prosthetic / Orthotic**

☐ **Rental** ☐ **Purchase**

☐ **Organ Transplant** (Pre-Transplant, Listing, Post-Transplant services)

☐ **Other**: _____

SECTION 5. SERVICES REQUESTED AND SUPPORTING DIAGNOSES

(If additional service codes are needed, please include them in a separate attached document.)

Service/Procedure Requested	CPT or HCPCS Code	Number of Units	Start Date	End Date	ICD-10 Code

Note: All requests must include supporting documentation such as H&P, laboratory, radiology, or diagnostic test results; current symptoms and functional impairments; treatment history; and any other relevant clinical records demonstrating medical necessity. Incomplete submissions may result in processing delays or adverse determination.