Gold Coast Health Plan℠
A Public Entity

# PROVIDER DISPUTE RESOLUTION

## *Grievance & Claims Correction Form*

### INSTRUCTIONS

**Gold Coast Health Plan has simplified the Provider Dispute Resolution process by making this grievance & claims correction form available to providers in accordance with various regulations that govern the health plan. These grievances, or disputes, may take various forms, including, but not limited to, the following: "Appeals" (requests to change a previous decision, i.e. regarding Authorization Requests, Medical Authorization Requests, or claims), or "Complaints" (an expression of dissatisfaction). In order to be effectively addressed, we have provided this form for providers to use when submitting grievances to Gold Coast Health Plan. If submitting a grievance please complete this form, attach all supporting documentation, and clearly describe the reason for your grievance. Grievances lacking information required for resolution will be returned to you with a request for more information.**

Gold Coast Health requests that you file an appeal only in situations where Gold Coast Health has received all documentation required to make a decision and you are now requesting reconsideration of that decision due to extenuating circumstances. If your claim was denied for timeliness of submittal or timeliness of follow-up, please do not submit an appeal unless you are also submitting verification of timeliness that meets criteria, or you have a valid Delay Reason Code.

Gold Coast Health Plan will acknowledge receipt of your grievance within 15 business days and send a written resolution to your grievance within 45 business days after the date of receipt. For claims corrections, your explanation of payment will serve as acknowledgment and resolution.

***Please submit this completed form with all supporting documentation attached to:***

### *Grievance Type*

| CLAIMS | HEALTH SERVICES | REFUNDS |
|---|---|---|
| ☐ **Claim Correction** *(copy of EOP attached)* | ☐ Retro-Review | ☐ Overpayment |
| ☐ Claims Billing Dispute | ☐ TAR Denial | ☐ Response to refund request letter |
| ☐ Claims Payment Dispute | ☐ Records for Review | ☐ Wrong Provider Paid |
| ☐ Claims Appeal *(Appealing Dispute Outcome)* | ☐ Appeal of Medical Necessity | ☐ Other _____ |
| ☐ Other _____ | ☐ Other _____ | |
| Gold Coast Health Plan<br>Attn: Provider Dispute / Claims Correction<br>P.O. Box 9176<br>Oxnard, CA 93031 | Gold Coast Health Plan<br>Attn: Health Services Correspondence<br>P.O. Box 9153<br>Oxnard, CA 93031 | Gold Coast Health Plan<br>Attn: Refunds Department<br>P.O. Box 9176<br>Oxnard, CA 93031 |

| *Provider Name: | Billing Provider NPI:: |
|---|---|
| *Provider Address: | |

Provider Type: ☐ MD ☐ Hospital ☐ SNF/LTC ☐ DME ☐ Home Health ☐ Ambulance ☐ Vision ☐ Transportation ☐ Other___

Claims Information: ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:____*

| Name of person submitting grievance: | Relationship to Provider:<br>☐Self ☐Office Staff ☐Billing Service ☐Other_____<br>Address of person submitting grievance: |
|---|---|

| **Member ID #:** | **Member First & Last Name:** | **Claim ID #:** |
|---|---|---|

| **Date (s) of Service:** *(*Required for Claim, Billing, and Reimbursement of Overpayment Disputes)* | **Original Claim Amount Billed:** | **Original Claim Amount Paid:** |
|---|---|---|

***Description of Grievance or reason for claim correction (please indicate specific line #'s, if applicable, and/or attach additional pages as needed and include all available supporting documentation):***

**[ ]** ***Check here if additional information is attached***