Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

PROVIDER GRIEVANCE FORM

INSTRUCTIONS

Gold Coast Health Plan makes a grievance resolution process 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 Plan requests that you file an appeal only in situations where Gold Coast Health Plan has received all documentation required to make a decision and you are now requesting reconsideration of that decision due to extenuating circumstances. ***Claim corrections should be submitted on a Claim Correction Form (available at www.goldcoasthealthplan.org) to our Claim Correction Department.*** 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
☐ Claims Billing Dispute	☐ Retro-Review	☐ Overpayment
☐ Claims Payment Dispute	☐ TAR Denial	☐ Response to refund request letter
☐ Claims Appeal *(Appealing Dispute Outcome)*	☐ Medical Authorization Appeal	☐ Wrong Provider Paid
☐ Other _____	☐ Other _____	☐ Other _____
Gold Coast Health Plan Attn: Claims Department P.O. Box 9152 Oxnard, CA 93031	Gold Coast Health Plan Attn: Health Services Correspondence P.O. Box 9153 Oxnard, CA 93031	Gold Coast Health Plan Attn: Refunds Department P.O. Box 9176 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: ☐Self ☐Office Staff ☐Billing Service ☐Other_____ 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***