Gold Coast Health Plan℠
A Public Entity

PROVIDER GRIEVANCE & APPEALS FORM

This form is to be used to submit complaints related to legal disputes, a complaint against a member, or if unsatisfied with the outcome of a previously filed claim dispute. For refunds and corrected claim complaints, please consult the ***GCHP Provider Manual***. If this is pertaining to disputes related to claim denials, overpayment and underpayment then please use the ***Provider Claim Dispute Resolution Form***.

Please complete the below form. Fields with an asterisk (*) are required.

- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Attach additional information to support the description of the dispute. Please include a copy of a claim that was previously processed.
- NOTE: Multiple "LIKE" claims are for the same provider and grievance but different members and dates of service. All original claim numbers are required.

Mail completed form to:

Gold Coast Health Plan
Attn: Provider Grievance & Appeals
P.O. Box 9176
Oxnard, CA 93031

*PROVIDER NAME:	*PROVIDER TIN:	*PROVIDER NPI:
*PROVIDER ADDRESS:		
CITY:	STATE:	ZIP CODE:

Provider Type: ☐ MD ☐ Hospital ☐ SNF/LTC ☐ DME ☐ Home Health ☐ Ambulance ☐ Vision ☐ Transportation ☐ Other ______
Claim Information: ☐ Single ☐ Multiple "LIKE" Claim, i.e., Multiple Claims for the same reason *(complete attached spreadsheet)*
Number of claims: ________

*Patient Name:		*Date of Birth:
*Health Plan ID Number:	*Original Claim Number:	
*Service "From/To" Date: (*Required for Claim, Billing, and Reimbursement of Overpayment Disputes)	*Original Claim Amount Billed:	Original Claim Amount Paid:

GRIEVANCE & APPEALS TYPES

☐ Legal Dispute
☐ Complaint – Member Involved Issues
☐ Dissatisfied with outcome of Provider Dispute Resolution
☐ Other

____
Contact Name (please print)

____
Title

(____)__________________________
Phone Number

(____)__________________________
Fax Number

____
Signature

____
Date

☐ Check here if additional information is attached