

PROVIDER RECONSIDERATION REQUEST FORM

Instructions:

- Please complete this form if you are seeking reconsideration of a previous determination.
- All fields must be completed. Please provide the full Contact Information or the resolution letter will be mailed to the address on file.
- **DISPUTE** request is for reconsideration of an original claim that has been previously denied or underpaid.
- **APPEAL** request is for reconsideration of an authorization denial or a notice of action.
- **GRIEVANCE** request is for reconsideration of a previously disputed claim in which the provider is not satisfied with the resolution outcome.
- If any information is missing, this form and all documentation will be mailed back.
- Multiple "Like" Claims are for Disputes and Grievances ONLY, and indicates there are separate claims for the same reason from the same provider for different members and/or dates of service.
- Be specific when completing the Description of Dispute and Expected Outcome.

Mail completed form to:

Gold Coast Health Plan
Attn: Provider Dispute & Grievance
P.O. Box 9176
Oxnard, CA 93031
OR
Email to: Grievances@goldchp.org

PROVIDER INFORMATION				
Provider NPI Number:	Provider Name:		Provider TIN:	
Provider Address:	City:		State:	Zip Code:
CLAIM TYPE	Check the one that applies: <input type="checkbox"/> Physician <input type="checkbox"/> SNF/LTC <input type="checkbox"/> Ambulance <input type="checkbox"/> Dialysis <input type="checkbox"/> Vision <input type="checkbox"/> Hospital Inpatient/Outpatient <input type="checkbox"/> DME <input type="checkbox"/> Transportation <input type="checkbox"/> Radiology <input type="checkbox"/> Other (please specify):			
RESOLUTION REQUEST TYPE	Check one: <input type="checkbox"/> DISPUTE <input type="checkbox"/> APPEAL <input type="checkbox"/> GRIEVANCE			
CLAIM INFORMATION	<input type="checkbox"/> SINGLE <input type="checkbox"/> MULTIPLE "LIKE" CLAIMS			
MEMBER INFORMATION				
GCHP Member ID Number:	Patient Name:		Date of Birth:	
Original Claim ID Number: <i>(if multiple claims, use the attached form)</i>	Original Claim Amount Billed:		Original Claim Amount Paid:	
Service Dates	From:	To:		
DISPUTE TYPE	Check the one that applies: <input type="checkbox"/> Claim Denial <input type="checkbox"/> Claim Underpayment <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Other (please specify):			
DESCRIPTION OF DISPUTE <i>(attach an additional sheet if needed)</i>				
EXPECTED OUTCOME				
Contact Name:	Title:	Signature: _____		
Phone Number:	Fax Number:	Date: _____		

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED. (PLEASE DO NOT STAPLE ADDITIONAL INFORMATION.)

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For use with multiple "LIKE" claims (claims disputed for the same reason)

	GCHP Member ID Number	Patient Name First	Patient Name Last	Date of Birth	Original Claim ID Number	Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

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CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED
(Please do not staple)