Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

PROVIDER CLAIM RECONSIDERATION FORM

PLEASE NOTE: IF ANY INFORMATION IS MISSING, THIS FORM AND ALL DOCUMENTATION WILL BE MAILED BACK TO YOU.

- Please complete this form if you are seeking reconsideration of a previous determination.
- Please complete 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.
- Be specific when completing the Description of Dispute and Expected Outcome.

Mail completed form to:

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

PROVIDER INFORMATION

Provider NPI Number _____ Provider Name _____ Provider TIN _____

Provider Address _____ City _____ State _____ Zip _____

CLAIM TYPE

Check the one that applies:

☐ Physician ☐ SNF / LTC ☐ Ambulance ☐ Dialysis ☐ Vision
☐ Hospital Inpatient/Outpatient ☐ High Risk OB ☐ Transportation ☐ Radiology
☐ Other *(please specify)*: _____

MEMBER INFORMATION

GCHP Member ID Number _____ **Patient Name** _____ **Date of Birth** _____

Original Claim ID Number _____ **Original Claim Amount Billed** _____ **Original Claim Amount Paid** _____
(if multiple claims, use the attached form)

Service Dates **From:** _____ **To:** _____

RESOLUTION REQUEST TYPE

Check one: ☐ DISPUTE ☐ APPEAL ☐ GRIEVANCE

DISPUTE TYPE

☐ Claim Denial ☐ Claim Underpayment ☐ Contract Dispute
☐ Appeal of Medical Necessity / Utilization Management Decision *(make selections below)*:
☐ Inpatient ☐ Outpatient
Select one (medical records required):
☐ Inpatient Level of Care ☐ Lack of Information Denial ☐ Non-Contracted
☐ No Prior Authrorization Obtained ☐ Additional Codes Requested for Authorization Review
☐ Other (please specify): _____

CLAIM INFORMATION:

☐ SINGLE ☐ MULTIPLE "LIKE" CLAIMS (complete the spreadsheet on Page 2)

DESCRIPTION OF DISPUTE AND EXPECTED OUTCOME
(attach an additional sheet if needed)

Contact Name _____ Title _____ Signature _____

Phone Number _____ Fax Number _____ Date _____

☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED. (PLEASE DO NOT STAPLE.)
When submitting medical documentation, please indicate the page number on which the clinical review starts for the dates you are requesting authorization. Page Number_____

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PROVIDER CLAIM RECONSIDERATION FORM

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								

Page _____ of _____

☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED

(Please do not staple)

711 East Daily Drive, Suite 106, Camarillo, CA 93010 | 1-888-301-1228 | **www.goldcoasthealthplan.org**

Rev. 3/2020