Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

GOLD COAST HEALTH PLAN OVERPAYMENT FORM

Provider Name: _____ NPI Number: _____ GCHP Provider Number: _____

Recording Time Period: (From) _____ (To) _____ Contact Person: _____ Contact Person's Phone Number: _____

1 Patient / Beneficiary Name	2 Patient ID Number	3 Claim Control Number (CCN)	4 Type of Bill	5 Beginning Service Date (MM/DD/YY)	6 Ending Service Date (MM/DD/YY)	7 Paid Date (MM/DD/YY)	8 GCHP Paid Amount	9 Other Insurance Paid Amount	10 Amount of Overpayment Included in this Submission	11 Method of Refund (C) Check (A) Claim Adjustment (X) Adjustment already submitted	12 Reason for Overpayment (1) COB (2) Duplicate (3) Contract Overpayment (4) Shared Cost (5) Other	13 Comments Primary Payer (Name & Billing Address)

Please mail to: Gold Coast Health Plan
PO Box 9152
Oxnard, CA 93031-8294
Attention: Shannon Robledo