

CLAIM CORRECTION FORM

Gold Coast Health Plan (GCHP) is working on ways to assist you with correcting your claim(s) and obtaining payment in the most efficient way possible.

To expedite the adjudication of your correction(s), please provide GCHP with the requested information below.

You must attach a copy of the corrected claim form (UB-04, CMS 1500, 25-1) to this form.

PLEASE RETURN THIS FORM AND THE CORRECTED CLAIM (INCLUDING ANY APPLICABLE ATTACHMENTS) TO:

**Gold Coast Health Plan
Attn: Corrected Claims
P.O. Box 9152
Oxnard, CA 93031**

* Required fields

*CLAIM NUMBER:	*MEMBER NAME (LAST, FIRST):	
*MEMBER ID NUMBER (CIN):	*PROVIDER NAME:	
*PROVIDER ADDRESS:	*PROVIDER NPI:	
CITY:	STATE:	ZIP CODE:

Provider Type: MD Hospital SNF/LTC DME Home Health Ambulance Vision Transportation

Other _____

*DESCRIPTION OF CORRECTION:

Contact Name (please print)

Title

(____) _____
Phone Number

(____) _____
Fax Number

Signature

Date