Gold Coast Health Plan OVERPAYMENT FORM

Please mail to:

Gold Coast Health Plan
Post Office Box
Oxnard, CA 93036
Attention: Shannon Godina

Provider Name:____

NPI Number:______________________________GCHP Provider Number:______________________

Reporting Time Period (From, To):____

Page __ of ___

Contact Person ____

Contact Person's Phone Number ____

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Patient/ Beneficiary Name	**Patient ID Number**	**Claim Control Number (CCN)**	**Type of Bill**	**Beginning Service Date (MM/DD/YY)**	**Ending Service Date (MM/DD/YY)**	**Paid Date (MM/DD/YY)**	**GCHP Paid Amount**	**Other Insurance Paid Amount**	**Amount of Overpayment included in this Submission**	**Method of Refund** (C) Check (A) Claim Adjmt (X) Adjustment already submitted	**Reason for Overpayment** (1) COB (2) Duplicate (3) Contract Overpaym't (4) Shared Cost (5) Other	**Comments Primary Payer (Name & Billing Address)**