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PROVIDER RECONSIDERATION REQUEST FORM

Instructions:

- Please complete this form if you are seeking reconsideration of a previous determination.
- All fields must be completed. 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 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 Disputes & Grievances
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 ____________

CLAIM TYPE	**Check the one that applies:** ☐ Physician ☐ SNF / LTC ☐ Ambulance ☐ Dialysis ☐ Vision ☐ Hospital Inpatient/Outpatient ☐ High Risk OB ☐ Transportation ☐ Radiology ☐ Other *(please specify)*: ______________________
RESOLUTION REQUEST TYPE	Check one: ☐ DISPUTE ☐ APPEAL ☐ GRIEVANCE
CLAIM INFORMATION	☐ SINGLE ☐ MULTIPLE "LIKE" CLAIMS

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:** ____________________

DISPUTE TYPE	**Check the one that applies:** ☐ Claim Denial ☐ Claim Underpayment ☐ Contract Dispute ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Other *(please specify)*: ______________________

DESCRIPTION OF DISPUTE
(attach an additional sheet if needed)

EXPECTED OUTCOME

Contact Name ____________________________ Title ______________________ Signature ____________________________

Phone Number ____________________________ Fax Number ____________________________ Date ____________________

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

Gold Coast Health Plan℠
A Public Entity

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PROVIDER RECONSIDERATION REQUEST 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)