COASTAL CARE SERVICES, INC.®
member quality redefined.

PROVIDER CLAIM APPEAL REQUEST FORM

This form should be used if you disagree with the outcome of your claims inquiry or have additional information which may warrant Coastal to re-evaluate its original decision.

- An appeal request must include claim numbers and supporting documentation (e.g. complete copy of the medical records and claim form).
- Review of a claim does not guarantee a change in payment disposition.
- An acknowledgement letter will be sent to you within ten (10) calendar days upon receipt of the Appeal Form.

Provider Information:

Provider Name: _____

Provider NPI #:_____

Claim Information:

Member Name: _____Claim Number(s):_____

Member Group & ID #:_____ Date(s) of Service: _____

Reason for Appeal:

- ☐ Timely Filing – Claims submitted beyond 180 days from DOS or 12 months from disallowed date
- ☐ Pricing – Incorrect payment or application of benefits
- ☐ Eligibility – Payment issued for ineligible charges, claim processed as incorrect member, incorrect order of payment or other issues related to member eligibility
- ☐ Medical Policy – Appeal a denial for failure to obtain prior authorization (Supporting documentation required).
- ☐ Other – Provide a detailed description

Description of Claim Appeal:

_____

_____

Supplemental Documentation Attached:

☐ Remittance Advice ☐ Refund ☐ Medical Records ☐ Other (e.g.Timely filing Documentation)

Contact Information:

Requester:_____ Phone #:_____ Date:_____

Mail completed form and attachments to:

Coastal Care Services, Inc.
Attention: Provider Claim Appeals
7875 NW 12 Street, Suite 200
Miami, FL 33126