

PROVIDER CLAIM DISPUTE/COMPLAINT 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 dispute 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 three (3) calendar days upon receipt of the Dispute Form.

Provider Information:

Provider Name: _____

Provider NPI #: _____

Claim Information:

Member Name: _____ Claim Number(s): _____

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

Reason for Dispute:

- 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
- Other – Provide a detailed description

Description of Claim Dispute:

Supplemental Documentation Attached:

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

Contact Information:

Requester: _____ Requester Signature: _____

Phone #: _____ Email: _____ Date: _____

Mail completed form and attachments to:

Coastal Care Services, Inc. -Attention: Provider Claim Disputes

7875 NW 12 Street, Suite 200, Doral, FL 33126

Fax: 855-481-0606

Note: This form should not be used for clinical appeals. To appeal a clinical determination, please obtain the member's consent and submit a member appeal directly to the member's health plan.