COASTAL PROVIDER COMPLAINT REQUEST FORM
FOR PRESTIGE HEALTH CHOICE

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.

- A provider complaint must include claim numbers and supporting documentation (e.g. copy of contract, pricing calculation 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) business days upon receipt of the Provider Complaint Request 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
- ☐ 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:_____ Requester Signature:_____

Phone #:_____ Email: _____ Date:_____

Mail completed form and attachments to:

Coastal Care Services, Inc. - Attention: Provider Claim Complaints
7875 NW 12 Street, Suite 200, Miami, 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 to:
Prestige Health Choice
Attn: Member Appeals

PO Box 7368
London KY 40742
Fax: 1-855-358-5847