COASTAL PROVIDER 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.

- 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 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: Claims Disputes
1200 NW 78 Avenue, Suite 100, 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 the member's Health Plan.