Gold Coast Health Plan℠
A Public Entity

CLAIM CORRECTION FORM

Gold Coast Health Plan is working on ways to assist you with correcting your claim(s) and obtaining payment in the most efficient way possible. To expedite the adjudication of your correction(s), please provide us with the requested information below.
You must attach a copy of the corrected claim form (UB-04, CMS 1500, 25-1) to this form.

PLEASE RETURN THIS FORM AND THE CORRECTED CLAIM (INCLUDING ANY APPLICABLE ATTACHMENTS) TO:

Gold Coast Health Plan
Attn: Corrected Claims
P.O. Box 9152
Oxnard, CA 93031

* *Denotes required fields*

*CLAIM NUMBER:	*MEMBER NAME (LAST, FIRST):	
*MEMBER ID NUMBER (CIN):	*PROVIDER NAME:	
*PROVIDER ADDRESS:		
CITY:	STATE:	ZIP CODE:

Provider Type: ☐ MD ☐ Hospital ☐ SNF/LTC ☐ DME ☐ Home Health ☐ Ambulance ☐ Vision ☐ Transportation

☐ Other _____

*DESCRIPTION OF CORRECTION:

_____ _____
Contact Name (please print) Title

(____)_____ (____)_____
Phone Number Fax Number

_____ _____
Signature Date