MedStar Family Choice

Provider Permission Form for Member Appeals

Member Name:______________________________DOB: ________________________

MSFC ID Number:____________________   Phone:________________________

Services Under Appeal:____

Name of Provider Appealing on Behalf of the Member:___________________________

The services listed above have been denied by MedStar Family Choice. I allow my provider to appeal these services on my behalf. This will include following the MedStar Family Choice member appeal process outlined in my member handbook. I understand that I may also file an appeal on my own or have my representative file on my behalf.

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Member Name Printed

________________________   ________________________
Member Signature   Date