DO NOT USE THIS FORM IF REQUESTING A FORMAL APPEAL of any type.
Use one of the required appeals document for Formal Appeal.

To return documents use one of the following:

Secure Email:
AdministrativeClaimReconsideration@Vestica.com
DC Mailing Address:
PO Box 2142 Milwaukee WI 53201
MD Mailing Address:
PO Box 2189 Milwaukee WI 53201

MedStar Family Choice

Medicaid Administrative Claim Reconsideration

☐ ALLIANCE ☐ DC ☐ MD

Date: _____

Claim Information:		**Requestor Information:**	
Claim#:	_____	Name:	_____
Member Name:	_____	Contact#:	_____
Member ID#:	_____	Fax:	_____
Date of Service:	_____	Email:	_____
Date of EOB:	_____		

Type of Claim:
☐ Office ☐ Outpatient ☐ ER ☐ Homecare/DME
☐ Inpatient ☐ Radiology ☐ Lab ☐ Other: _____

Amount in Question: $ _____
Provider Name: _____
Group/Facility Name: _____
TIN/NPI#: _____

Reason for Reconsideration Request

Explain exactly what you are requesting MedStar Family Choice to reconsider. Attach copy of claim, EOB, and other supporting documentation. **ONLY submit MEDICAL RECORDS if they have been requested**

___ Timely Filing (**Proof of timely filing required**)
___ Corrected Claim (including modifiers)
___ Coordination of Benefits (COB)
___ Processed PAR Provider as Out of Network
___ Denied for lack of Authorization
___ Denied duplicate in error
___ Previously requested information attached
___ Not paid at contracted rates
___ Processed with incorrect TIN
___ Refunds/Stop payments
___ OTHER: _____
_____
_____
_____
_____

Form must be completed in its entirety or reconsideration will not be processed. If there are additional questions contact Customer Service at 1-800-261-3371. Please allow 45 days for review and completion of any claim adjustment deemed necesary. You will be notified of our decision via EOB.