MedStar Family Choice

DO NOT USE THIS FORM IF REQUESTING A CLINICAL APPEAL.
Return to the address below:

Mailing Address:
P.O. Box 43730
Baltimore, MD 21236
Or Securely Email the form to:
MFCClaims@medstar.net
Appeals filed with this form that do not meet all the requirements of an appeal will be handled as a Claims Reconsideration request. A response to a Claims Reconsideration is sent via EOB in approximately 45 days from receipt by MFC.

Medicaid Administrative Claim Appeal

☐ ALLIANCE ☐ DC ☐ MD

Date: _____

Claim Information:

Claim#: _____
Member Name: _____
Member ID#: _____
Date of Service: _____
Date of EOB: _____

Requestor Information:

Name: _____
Contact#: _____
Fax: _____
Email: _____

Type of Claim:

☐ Office ☐ Outpatient ☐ ER ☐ Homecare/DME

☐ Inpatient ☐ Radiology ☐ Lab ☐ Other: _____

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

Reason for Administrative Appeal

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. This form should not be used for denials based on medical necessity.**

___ 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: _____

_____
_____
_____
_____

This form must be completed in its entirety or appeal will not be processed as an appeal. It will be handled as a Claims Reconsideration Request and a response will be sent via EOB within 45 days of receipt or the entire submission will be returned to you if there is not enough information submitted for us to make a determination.