MedStar Family Choice

Return via secure email or fax

Secure Email: MFCClaims@medstar.net
Secure Fax: 410-933-3091

Date: _____

Medicaid
Claim Assistance/Project Request

☐ ALLIANCE ☐ DC ☐ MD

Requestor Information

Contact Name: _____

Contact#: _____

Email Address: _____

Prov/Group/Facility Name: _____

TIN/NPI#: _____

Project Information

___ Single issue (one member)
___ Multiple issues (one member)
___ Single issue (multiple members)
___ Multiple issues (multiple members)

Summarize specific issue in detail. **Attach Copy Of EOB(s) or Claim(s) With Examples:**

_____
_____
_____
_____
_____
_____
_____

Date(s) of service involved: _____

Customer Service Call Ref#: _____ **Date:** _____

Appealed? ___ Yes ___ No **Date**: _____

Reconsideration requested? ___ Yes ___ No **Date** : _____

If not followed up on please explain why: _____
_____
_____

Form must be completed in its entirety or request will not be processed.