Return to the MedStar Family Choice address below:

DC Mailing Address:
P.O. Box 43850
Baltimore, MD 21236

MD Mailing Address:
P.O. Box 43790
Baltimore, MD 21236

MedStar Family Choice

☐ ALLIANCE ☐ DC ☐ MD

Formal Medical Necessity Appeal

Date: _____

Claim Information:

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

Requestor/Response Information:

Name: _____
Contact#: _____
Fax#: _____
Address: _____
_____
_____

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

Claim amount in question: $ _____
Provider Name: _____
Group Name: _____

Reason for Appeal/Review of Medical Records:

Explain exactly what you are requesting MedStar Family Choice to reconsider. Attach copy of EOB and other supporting documentation. **MEDICAL RECORDS REQUIRED** when using this form.

___ Denied Days (Day/Dates Being Appealed):_____
___ Non-Clinical Reason: _____
___ Service not covered
___ Pre-Service Denial/Service Type: _____
___ No Authorization
___ OTHER (does not include administrative reasons, use the proper form for these types of appeals):

_____
_____
_____
_____

Form must be completed in its entirety or appeal will not be processed. Please note: this form is only to be used for claim denials that require a Medical Necessity decision. If the denial was based on an Administrative reason (like timely filing, billing issues, etc) please use the Administrative Appeals form instead.