MedStar Family
Choice

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.

____
Member Name Printed

________________________ ________________________
Member Signature Date