



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