MedStar Family Choice

Return to:

MedStar Family Choice
P.O. Box **43790**
Baltimore, MD 21236
Attention: Denials & Appeals
Phone: 800-905-1722, option 3

Medicaid Clinical Appeal Form

☐ Level 1 ☐ Level 2 Date: _____

Claim Information:

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

Requestor Information:

Name: _____
Phone: _____
Email: _____
Fax: _____
Address: _____

Type of Appeal:

☐ Office ☐ Outpatient ☐ ER ☐ Homecare/DME

☐ Inpatient ☐ Radiology ☐ Lab ☐ Other: _____

Billed Amount in Question: $ _____ Group Name: _____
Provider Name: _____ TIN#: _____

Reason for Appeal: Explain exactly why you believe MedStar Family Choice should overturn the denial.

Form is only used for denials that require a Medical Necessity decision (authorized days/service, etc.)
Use the Medicaid Claim Appeal form for administrative denial reasons (untimely filing, MUE, billing issue, etc.)

MEDICAL RECORDS REQUIRED WHEN USING THIS FORM.
Include any additional supporting documents.

☐ Denied Dates Being Appealed: _____

☐ No Authorization for Service ☐ Non-Covered Benefit ☐ No Medical (clinical) Records

☐ Other/ Pre-Service Denial/ Service Type/ CPT Codes: _____

_____

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_____

Complete form in its entirety to prevent delay in processing the appeal. Please contact us at the number above for questions related to completing the form.

Revised 12/2018