

## MedStar Family Choice Payment Dispute Form

This form is for claim payment disputes only. Use this form to request a review of claims payment received that does not correspond with the payment expected.

**DO NOT USE THIS FORM IF REQUESTING AN APPEAL FOR DENIED SERVICE.**

### Instructions for Completing the Payment Dispute Form

- One dispute request per form. Multiple claims can be attached with the same dispute reason.
- Complete form in its entirety to prevent delay in processing reconsideration.
- We will respond to your request via EOB within 30 calendar days from receipt of dispute form.
- New claims are not to be attached to this form. New claims will be returned to the submitter.
- Illegible and/or incomplete forms will not be processed.
- Fields designated by an asterisk (\*) are required.

Select the corresponding reason for reconsideration:

- **Coordination of Benefits:** Copy of EOB and claim is required.
- **Contract Rate:** Claim was not processed according to contract terms. This includes Single Case Agreements (SCA), etc. Supporting contract documentation required.
- **Eligibility Issue:** Claim originally denied for eligibility, however member eligibility has been updated and MedStar Family Choice now covers the member for the Date of Service (DOS).
- **Authorization on file:** Claim denied for an authorization, however approved authorization for DOS on file. Include Authorization #.
- **Services do not require an authorization:** Claim denied for an authorization, however services were self-referred.
- **Invoice Attached:** Claim originally denied for lack of an invoice. Attach a clear copy of the manufacturer's invoice, for service, device, or drug. Be sure the services match the claim. For drugs, the invoice should clearly show the per-unit cost of the drug and the NDC/Description must match the claim submission.
- **Itemized Bill Attached:** Claim originally denied for an itemized bill.
- **Paid to wrong provider:** Claim paid to the wrong provider.
- **Other:** Comments required.

## MedStar Family Choice Payment Dispute Form

Date Submitted: \_\_\_\_\_

### REQUESTOR INFORMATION

*Name:	*Phone:
*Address:	*City/State/Zip:
Fax:	Email:

### CLAIM INFORMATION

*MedStar Family Choice ID #:	*Member Name:
*Claim #: <b>If multiple claims, attach all claim numbers</b>	*Date of Service:
*Provider Name:	*Total Billed Amount:
*Tax ID:	*NPI:

Fields designated by an asterisk (\*) are required

**CLAIM DISPUTE REASON:** Check applicable box that correspond to reconsideration request. Attach copy of claim, EOB, and other supporting documentation.

<input type="checkbox"/> <b>Coordination of Benefits (COB):</b> <i>Need copy of EOB and claim (required)</i>
<input type="checkbox"/> <b>Contract Rate</b>
<input type="checkbox"/> <b>Eligibility Issue</b>
<input type="checkbox"/> <b>Authorization on file.</b> Auth# _____ <i>was obtained.</i>
<input type="checkbox"/> <b>Services do not require an authorization</b>
<input type="checkbox"/> <b>Invoice Attached</b>
<input type="checkbox"/> <b>Itemized Bill Attached:</b> <i>Please attach itemized bill.</i>
<input type="checkbox"/> <b>Paid to wrong provider</b>
<input type="checkbox"/> <b>Other (comments required)</b>
<b>Notes/Comments:</b>

**Send this form and all supporting documents to:**

Secure Email: [MFCPaymentDisputes@skygenusa.com](mailto:MFCPaymentDisputes@skygenusa.com) or

Address: **MedStar Family Choice**  
 PO Box 2189  
 Milwaukee, WI 53201  
**ATTN: Payment Disputes**  
**Phone: 800-261-3371**