MedStar Family Choice

Medicaid Administrative Claim Reconsideration Form

DO NOT USE THIS FORM IF REQUESTING AN APPEAL OF ANY TYPE.
Use the appropriate *Medicaid Claim Appeal* or *Medicaid Clinical Appeal* form.

Date: ___ / ____ / ________

Instructions for Completing

Form must be completed in its entirety or reconsideration will not be processed. Please allow 30 days for review and completion of any claim adjustment. You will be notified of our decision via an EOB. Requests that are not legible and/or does not have complete details will not be processed. **Submit request to:**

Secure Email: AdministrativeClaimReconsideration@skygenusa.com or
Address: **Medicaid Administrative Claim Reconsideration**
PO Box 2189
Milwaukee, WI 53201
800-261-3371

Claim Information:

Claim#: ____________________
Member Name: ____________________
MFC ID#: ____________________
Date of Service: ____________________
Provider Name: ____________________
Grp/Fac Name: ____________________
TIN/NPI#: ____________________
Date of EOB: ____________________

Requestor Information:

Name: ____________________
Phone: ____________________
Fax: ____________________
Email: ____________________

Reason for Reconsideration Request: Indicate exactly what you are requesting MedStar Family Choice to reconsider.

Attach copy of claim, Explanation of Benefits (EOB), and other supporting documentation. New claims that have not been submitted for processing should not be attached. Follow normal claim submission guidelines.

☐ Corrected Claim(s) (Must complete Box 22 on the CMS-1500)

☐ Previously requested information attached (e.g. invoice, itemized bill, etc.)

☐ Processed PAR Provider as Out of Network

☐ Denied for lack of Authorization in error

☐ Other: ____________________

☐ Denied duplicate in error

☐ Coordination of Benefits (COB)

☐ Allowed vs. Contracted Amount

☐ Processed with incorrect TIN

☐ Refunds/Stop payments