MedStar Family Choice

Medicaid Claim Assistance / Project Request Form

Date: ___ / ___ / _____

Instructions for completing Project Request Form

This form is to be used after all other claims assistance processes (e.g. Claims Processing Center at **800-261-3371**, Medicaid Administrative Claim Reconsideration, and/or Medicaid Claim Appeal) has been exhausted and assistance is still needed to resolve open issues. Please allow **30** days for review and completion.

Please note: Requests that are not legible and/or does not have complete details will not be processed.

Submit request to:
Secure Email: MFCClaims@medstar.net or
Secure Fax: 410-933-3091

Requestor/Provider Information

Contact Name: _____

Contact #: _____ Email Address: _____

Prov/Group/Facility Name: _____

TIN/NPI: _____

Reason for Project Request

Summarize specific issue in detail. **Attach Copy of EOB(s) or Claim (s) with Examples (Required)**

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