MedStar Family Choice

Return to:
MedStar Family Choice
P.O. Box **43730**
Baltimore, MD 21236
800-261-3371
Fax to 410-350-7455

Medicaid Administrative Claim Appeal Form

☐ Level 1 ☐ Level 2 Date: ______________________________

Claim Information:

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

Requestor Information:

Name: ______________________
Phone: ______________________
Fax: ______________________
Email: ______________________

Type of Claim: ☐ Office ☐ Outpatient ☐ ER ☐ Homecare/DME
☐ Inpatient ☐ Radiology ☐ Lab ☐ Other: ________________

Billed Amount in Question: $ _____________ Group/Facility Name: ______________________
Provider Name: ______________________ TIN/NPI#: ______________________________

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

Form is only used for administrative denial reasons (untimely filing, MUE, billing issues, etc.) Attach copy of claim, EOB, and other supporting documentation.

ONLY submit MEDICAL RECORDS if they have been requested.

☐ Timely Filing (**Proof of timely filing required**)
☐ Corrected Claim (including modifiers)
☐ Coordination of Benefits (COB)
☐ Processed PAR Provider as Out of Network
☐ Denied for lack of Authorization
☐ Denied duplicate in error
☐ Previously requested information attached
☐ Not paid at contracted rates
☐ Processed with incorrect TIN
☐ Refunds/Stop payments
☐ OTHER: ____
____
____
____

Complete form in its entirety or request will not be processed as an appeal. It will be handled as a Claims Reconsideration Request and a response will be sent via EOB within 45 days of receipt or the request will be returned if there is not enough information to make a determination.

Revised 4/2020