MedStar Family Choice

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Provider Permission Form for Member Appeals

Member Name:_____ DOB: _____

MFC ID Number: _____ Phone:_____

Services Under Appeal:_____

Name of Provider Appealing on Behalf of the Member:_____

The services listed above have been denied by MedStar Family Choice. I allow my provider to appeal these services on my behalf. This will include following the MedStar Family Choice member appeal process outlined in my member handbook. I understand that I may also file an appeal on my own or have my representative file on my behalf.

_____
Member Name Printed

_____ _____
Member Signature Date