

MedStar Family Choice Healthy DC Plan Appeal Form

This form is to be used to appeal a medical necessity or administrative denial. Please submit one form for each appeal. Incomplete appeal forms will be returned unprocessed. For more detailed information on appeal policies and procedures, please refer to the your Provider Participation Agreement. Send this form with a letter stating your reason for appeal and all pertinent medical documentation to support the appeal request to the address or fax below.

MedStar Family Choice Healthy DC Plan

Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

Clinical/Medical Necessity: 410-350-7435

Administration/Claim: 410-350-7455

Date Submitted: _____

Type of Appeal: ☐ Clinical ☐ Administrative

Line of Business: ☐ Healthy DC Plan

Level of Appeal: ☐ 1st Level ☐ 2nd Level

Provider Information:

*Provider Name:	*Group/Facility Name:
*Tax ID #:	*NPI:
*Phone #:	Fax #:
*Contact Name:	

Member Information:

*Last Name:	*First Name:
* MedStar Family Choice ID #:	*Date of Birth:

Claim Information:

*Claim #	Billed Amount:
*Date of Service	

Reason for Appeal:

<input type="checkbox"/> Pharmacy <input type="checkbox"/> Preservice <input type="checkbox"/> Clinical Review for Medical Necessity <input type="checkbox"/> ER/EMTALA	<input type="checkbox"/> Administrative Denial <input type="checkbox"/> Unlisted/Unspecified Code w/Medical Records <input type="checkbox"/> Code Review/NCCI/MUE <input type="checkbox"/> Other (Comments required)
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Notes/Comments:

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