

MedStar Family Choice Healthy DC Plan Payment Dispute Form

This form is to be used for claim payment disputes only. Please submit one form for each claim. Multiple claims may be attached with the same dispute reason. Fields designated with an asterisk (*) are required. Incomplete payment dispute forms will be returned unprocessed. Do not submit new claims with this form. For more detailed information on payment dispute policies and procedures, please refer to the your Provider Participation Agreement. **Note: This form is not to be used for clinical or administrative appeal requests.**

Send this form and all supporting documents to the secure message in the MFC Claims Portal, mail to the below address or access our secure Provider Portal and submit payment disputes using the email option using the links below:

MedStar Family Choice Healthy DC Plan
ATTN: Payment Disputes
PO Box 211702
Eagan, MN 55121

District of Columbia Provider Portal

<https://mfcdcprovider.healthtrioconnect.com/app/index.page>

Date Submitted: _____

Line of Business: ☐ Healthy DC Plan

Requestor Information:

* Name:	* Phone:
* Address:	* City/State/Zip:
Fax:	Email:

Member Information:

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

Claim Information:

* Claim #	Billed Amount:
* Date of Service	

Payment Dispute Reason:

<input type="checkbox"/> COB/OHI Issues: <i>need primary carrier EOP</i>	<input type="checkbox"/> Timely Filing (<i>attach proof</i>)
<input type="checkbox"/> Overpayment or Underpayment per Contracted Rate	<input type="checkbox"/> Duplicate Claim
<input type="checkbox"/> Eligibility Issue	<input type="checkbox"/> Paid to Wrong Provider
<input type="checkbox"/> Authorization on file. Auth# _____	<input type="checkbox"/> Invoice/Itemized Bill Attached
<input type="checkbox"/> Single Case Agreement	<input type="checkbox"/> Other (<i>comments required</i>)

Notes/Comments: