MedStar Family Choice

Medicaid 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 Provider Manual or your Provide 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
Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

Clinical/Medical Necessity: 410-350-7435
Administration/Claim: 410-350-7455

Date Submitted: _____
Line of Business: ☐ Maryland ☐ DC

Type of Appeal: ☐ Clinical ☐ Administrative
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:

☐Pharmacy ☐Preservice ☐Clinical Review for Medical Necessity ☐ER/EMTALA	☐Administrative Denial ☐Unlisted/Unspecified Code w/Medical Records ☐Code Review/NCCI/MUE ☐Other (Comments required)
Notes/Comments:	