MedStar Family Choice

Medicaid Appeal Form

This form is to be used to appeal a clinical/medical necessity or administrative denial. Send this form with a letter stating the reason for an appeal and all pertinent medical documentation to support the appeal request to the below address:

Address: **MedStar Family Choice**
Appeals Processing
P.O. Box 43790
Baltimore, MD 21236

This form should not be used for Payment Disputes unless the provider is appealing the Payment Dispute decision.

Instructions for Completing Appeal Form

- Medical records must be submitted with form.
- Submit a copy of the claim (Only for Administrative appeals).
- Form must be completed in its entirety to prevent delay in processing appeal.
- One appeal request per form.
- Fields designated by an asterisk (*) are required.
- Must select the Plan Type (Maryland or DC), Appeal Type (Clinical or Claims) and the Appeal Level (I or II).

Appeal Type

Claim (Administrative) appeals do not require a review by clinicians. Reasons include untimely filing and duplicate claim denials.

Clinical appeals require review by clinicians for initial adverse decisions based on medical necessity, experimental or investigational coverage criteria, as well as services that were denied for not receiving prior authorization.

Appeal Reason Explanations

Select the corresponding reason for appeal

- ***Timely Filing:*** You believe the claim incorrectly denied as untimely. Must attach valid proof of timely filing.
- ***Duplicate Claim***: You believe claim denied as a duplicate incorrectly based on other circumstances. Must provide documentation of non-duplication.
- ***Clinical Review for Medical Necessity***: You believe services were medically necessary.
- ***No Authorization Approved for this Service***: You did not submit a request for a prior authorization. Or the service authorized does not match what we have on file.
- ***Non-Covered Benefit***: Medical documentation required.
- ***No Authorization of Service***: You did not submit a request for a prior authorization. Or the service authorized does not match what we have on file.
- ***EMTALA***: You did not submit any medical records with your ER claim.
- ***Unlisted/Unspecified Code***: Medical documentation (i.e. operative report) should be submitted, along with supporting information outlining the decision-making process and the medical rationale for performing the service.
- ***Medically Unlikely Edit (MUE)***: Medical documentation required to support medical necessity review of units over MUE limit.
- ***Other***: Comments required. Include pertinent documentation that will support appeal position.

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Medicaid Appeal Form

Date Submitted: _____

*Plan Type: (Select one)	*Appeal Type: (Select one)	*Appeal Level: (Select one)
☐ Maryland	☐ Clinical (Medical Necessity Review) *(MUST include Medical Records)	☐ Level I
☐ District of Columbia	☐ Administrative	☐ Level II

Provider Information

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

Patient Information

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

Claim Information

*Claim # (Only 1 per Appeal):	Billed Amount:
*Service From Date:	Service Thru Date:

Fields designated by an asterisk (*) are required

Appeal Reason:

☐ Timely Filing (attach proof of timely filing) ☐ Duplicate Claim (need proof of non-duplication) ☐ Clinical Review for Medical Necessity ☐ No Authorization Approved for this Service ☐ EMTALA	☐ Non-Covered Benefit ☐ No Authorization of Service ☐ Unlisted/Unspecified Code ☐ Medically Unlikely Edit (MUE) ☐ Other (Comments required)
Notes/Comments:	

Send this form and all supporting documents to:

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Clinical/Medical Necessity appeal requests can be faxed to **410-350-7435**.

Administration/Claim appeal requests can be faxed to **410-350-7455**.