MedStar Health

DO NOT USE THIS FORM IF REQUESTING A CLINICAL APPEAL.

This form is not required, but can be submitted along with the additional formal documentation

Return to the address below:

MedStar Select or MedStar Medicare Choice
PO Box 269
Pittsburgh, PA 15230-0269

MedStar Select and MedStar Medicare Choice Claim Appeal

☐ DC ☐ MD

Date: _____

Claim Information:		**Requestor Information:**	
Claim#:	_____	Name:	_____
Member Name:	_____	Contact#:	_____
Member ID#:	_____	Fax:	_____
Date of Service:	_____	Email:	_____
Date of EOB:	_____		

Type of Claim: ☐ Office ☐ Outpatient ☐ ER ☐ Homecare/DME

☐ Inpatient ☐ Radiology ☐ Lab ☐ Other: _____

Amount in Question: $ _____

Provider Name: _____

Group/Facility Name: _____

TIN/NPI#: _____

Reason for Appeal

Explain exactly what you are requesting MedStar Select or MedStar Medicare Choice to reconsider. Attach copy of claim, EOB, and other supporting documentation. **ONLY submit MEDICAL RECORDS if they have been requested**

___ Timely Filing (**Proof of timely filing required**)
___ Corrected Claim (including modifiers)
___ Coordination of Benefits (COB)
___ Processed PAR Provider as Out of Network
___ Denied for lack of Authorization
___ Denied duplicate in error
___ Previously requested information attached
___ Not paid at contracted rates
___ Processed with incorrect TIN
___ Refunds/Stop payments
___ OTHER: _____

_____

_____

_____

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*Form is optional for providers to be submitted as a supplemental document with Formal Appeals Request and is not required.