MedStar Health

Return via email or fax.

Email: msfcproviderrelations2@medstar.net
Fax: 410-933-3077

MedStar Select and MedStar

Date: _____

Medicare Choice Provider

☐ DC ☐ MD

Claim Assistance/Project Request

Requestor Information

Contact Name: _____

Contact#: _____

Email Address: _____

Prov/Group/Facility Name: _____

TIN/NPI#: _____

Project Information

___ Single issues (one member)

___ Single issues (multiple members)

___ Multiple issues (one member)

___ Multiple issues (multiple members)

Summarize specific issue in detail. **ATTACH COPY OF EOB(S) WITH EXAMPLES:**

_____

_____

_____

_____

_____

_____

_____

Date(s) of service involved: _____

Customer Service Call Ref#: _____ **Date:** _____

Appealed? ___ Yes ___ No **Date**: _____

Reconsideration requested? ___ Yes ___ No **Date** : _____

If not followed up on please explain why: _____

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