MedStar Health

Return to the MedStar Select or MedStar Medicare Choice address below:

Mailing Address:
MedStar Select or MedStar Medicare Choice
P.O Box 269
Pittsburgh, PA 15230-0269

Formal Medical Necessity Appeal

☐ DC ☐ MD

☐ Administrative ☐ Clinical

Date: _____

Claim Information:

Claim#: _____
Member Name: _____
Member ID#: _____
Date of Service: _____
Date of EOB: _____

Requestor Information:

Name: _____
Contact#: _____
Fax: _____
Email: _____

Type of Claim:

☐ Office ☐ Outpatient ☐ ER ☐ Homecare/DME

☐ Inpatient ☐ Radiology ☐ Lab ☐ Other: _____

Claim amount in question: $ _____

Provider Name: _____

Group Name: _____

TIN#: _____

Reason for Appeal

Explain exactly what you are requesting MedStar Select or MedStar Medicare Choice to reconsider. Attach copy of EOB and other supporting documentation. **MEDICAL RECORDS REQUIRED.**

___ Denied Days (Day/Dates Being Appealed):_____
___ Non-Clinical Reason: _____
___ Service not covered
___ Pre-Service Denial/Service Type: _____
___ No Authorization
___ OTHER: _____

_____

_____

_____

_____

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