MedStar Family Choice

MedStar Family Choice Payment Dispute Form

This form is to be used for claim payment disputes only. Please submit one form for each claim. Multiple claims may be attached with the same dispute reason. Fields designated with an asterisk (*) are required. Incomplete payment dispute forms will be returned unprocessed. Do not submit new claims with this form. For more detailed information on payment dispute policies and procedures, please refer to the Provider Manual or your Provide Participation Agreement. ***Note: This form is not to be used for clinical or administrative appeal requests.***

Send this form and all supporting documents to the secure message in the MFC Claims Portal, mail to the below address or access our secure Provider Portal and submit payment disputes using the email option using the links below:

MedStar Family Choice
ATTN: Payment Disputes
PO Box 211702
Eagan, MN 55121

District of Columbia Provider Portal
https://mfcdcprovider.healthtrioconnect.com/app/index.page
Maryland Provider Portal
https://mfcmdprovider.healthtrioconnect.com/app/index.page

Date Submitted: _____

Line of Business: ☐ Maryland ☐ DC

Requestor Information:

*Name:	*Phone:
*Address:	*City/State/Zip:
Fax:	Email:

Member Information:

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

Claim Information:

*Claim #	Billed Amount:
*Date of Service	

Payment Dispute Reason:

☐COB/OHI Issues: *need primary carrier EOP*	☐Timely Filing (*attach proof*)
☐Overpayment or Underpayment per Contracted Rate	☐Duplicate Claim
☐Eligibility Issue	☐Paid to Wrong Provider
☐Authorization on file. Auth# _____	☐Invoice/Itemized Bill Attached
☐Single Case Agreement	☐Other (*comments required*)

Notes/Comments: