MedStar Family Choice

DISTRICT OF COLUMBIA

MedStar Family Choice District of Columbia (MFC-DC)
Payment Dispute Form

This form is for claim payment disputes only. Use this form to request a review of claims payment received that does not correspond with the payment expected.

DO NOT USE THIS FORM IF REQUESTING AN APPEAL FOR DENIED SERVICE.

Instructions for Completing the Payment Dispute Form

- One dispute request per form. Multiple claims can be attached with the same dispute reason.
- Complete form in its entirety to prevent delay in processing reconsideration.
- We will respond to your request via EOP within 30 calendar days from receipt of dispute form.
- New claims are not to be attached to this form. New claims will be returned to the submitter.
- Illegible and/or incomplete forms will not be processed.
- Fields designated by an asterisk (*) are required.

Select the corresponding reason for reconsideration:

- ***Coordination of Benefits***: Copy of EOP and claim is required.
- ***Contract Rate***: Claim was not processed according to contract terms. This includes Single Case Agreements (SCA), etc. Supporting contract documentation required.
- ***Eligibility Issue***: Claim original denied for eligibility, however Enrollee eligibility has been updated and MFC-DC now covers the Enrollee for the Date of Service (DOS).
- ***Authorization on file***: Claim denied for an authorization, however approved authorization for DOS on file. Include Authorization #.
- ***Services do not require an authorization***: Claim denied for an authorization, however services were self-referred.
- ***Invoice Attached***: Claim originally denied for lack of an invoice. Attach a clear copy of the manufacturer's invoice, for service, device, or drug. Be sure the services match the claim. For drugs, the invoice should clearly show the per-unit cost of the drug and the NDC/Description must match the claim submission.
- ***Itemized Bill Attached***: Claim originally denied for an itemized bill.
- ***Paid to wrong provider***: Claim paid to the wrong provider.
- ***Other***: Comments required

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Date Submitted: _____

REQUESTOR INFORMATION

*Name:	*Phone:
***A**ddress:	*City/State/Zip:
Fax:	Email:

CLAIM INFORMATION

*MFC-DC ID #:	*Enrollee Name:
*Claim #: **If multiple claims, attach all claim numbers**	*Date of Service:
*Provider Name:	*Total Billed Amount:
*Tax ID:	*NPI:

Fields designated by an asterisk (*) are required

CLAIM DISPUTE REASON: Check applicable box that correspond to reconsideration request. Attach copy of claim, EOP, and other supporting documentation.

☐ **Coordination of Benefits (COB):** *Need copy of EOP and claim (required)*
☐ **Contract Rate**
☐ **Eligibility Issue**
☐ **Authorization on file was obtained. Authorization #:**
☐ **Services do not require an authorization**
☐ **Invoice Attached**
☐ **Itemized Bill Attached:** *Please attach itemized bill.*
☐ **Paid to wrong provider**
☐ **Other (comments required)**
Notes/Comments:

Send this form and all supporting documents to:

Address: **MedStar Family Choice District of Columbia**
PO Box 211702
Eagan, MN 55121
ATTN: Payment Disputes
Phone: 800-261-3371