PROVIDER APPEAL/ RECONSIDERATION FORM

Use this form as part of the Maryland Physicians Care (MPC) Appeal/Reconsideration process to address the decision made during the request for review process. Do not use this form for first-time claims or corrected claims. For corrected claims, please use the claims resubmission process outlined in the provider manual.

All claim Requests for Reconsideration, and Claim Appeals must be received within 90 calendar days from the date of the Medicaid Remittance. All fields below are required. Failure to complete the form may result in a delay of your request.

An Appeal is a formal written request to MPC for reconsideration of a medical adverse decision. Types of claim denials that could result in an appeal include but are not limited to:

- Services/Precertification
- Experimental/Investigational
- Not Medically Necessary

A Reconsideration is a request for MPC to review a claim with additional information submitted by the provider that was not previously submitted. Supporting documentation for review include, but is not limited to:

- Copy of Invoice for Pricing Review
- Additional documentation which would clarify services

Member's Name:	Member's Medicaid Number:
Date(s) of Service:	Control/Claim Number(s):
Medicaid Remittance Date:	Billed Charge(s):
Provider Name:	Provider TIN Number:
Medicaid Provider Number:	Provider Contact Number:
Contact Name:	Contact Address:

Please check the appropriate box below.

☐ APPEAL: Must include medical records or medical information.

☐ RECONSIDERATION: The attached claim(s) was originally submitted with incorrect/insufficient information.

Please include relevant claim information and any supporting medical or clinical documentation with this form and mail to the following address:

Maryland Physicians Care
PO Box 5080
Farmington, MO 63640-5080

MPC will make reasonable efforts to resolve this request within 30 calendar days of receipt. Based upon the information submitted, we will either uphold our original decision (if we uphold our original decision, we will send you a letter stating we are upholding our original decision and state our reason(s) for the decision) or overturn out original decision (if we overturn our original decision, we will send you a letter stating our decision and any additional payment due will appear on the provider remittance.)

This form may be photocopied.