MARYLAND physicians care
MANAGED CARE ORGANIZATION

PROVIDER APPEAL FORM

Please use this form as part of the Maryland Physicians Care (MPC) Appeal process to address the decision made during the request for review process. Do not use this form for first-time claims or corrected claims.

ATTENTION: Do not use this form for provider inquiries, resubmissions or corrected claims. This form is only to be used for appealing denied or partially denied claims.

All Appeal requests must be received within 90 business days from the date of the Medicaid Remittance. All fields below are required. Please note that Claim Numbers are mandatory. Failure to complete the form may result in a delay of your request.

An Appeal is a formal written request to MPC to review and reconsider previously denied service.

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 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 90 business days of receipt. Based upon the information submitted, we will provide a letter with the results of the appeal. If the appeal result is overturned, any additional payment will be reflected on the provider remittance.

This form may be photocopied.