



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.

Table with 2 columns and 7 rows for member and provider 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 1104
Portland, ME 04104

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.