MedStar Family Choice

5233 King Avenue, Suite 400
Baltimore, MD 21237
P 800-905-1722
F 410-933-3077
MedStarFamilyChoice.com

"REFUND LOCKBOX CHANGE"

Maryland HealthChoice - DC Healthy Families - DC Healthcare Alliance

Effective immediately, the MedStar Family Choice Refund Lockbox Address has changed.

If a provider receives an overpayment, the provider shall report and refund such overpayment within 60 calendar days of the date on which the overpayment was identified by Provider, in a manner consistent with the requirements of applicable law, including without limitation 42 U.S.C. 1320a-7k(d) and applicable regulations.

Please submit refunds using the Overpayment/ Refund Form located on MedStarFamilyChoice.com along with a copy of the Remittance Advice and any supporting documentation identifying the overpayment to:

MedStar Family Choice
PO Box 715639
Philadelphia, PA 19171-5639

For questions concerning this Provider Alert, please contact the MedStar Family Choice Claims Department at 800-261-3371.

MedStar Family Choice
MedStarFamilyChoice.com
Enclosure: Provider Overpayment Refund Submission Form

MedStar Family Choice

Provider Overpayment Refund Submission Form

INSTRUCTIONS

This form should be used anytime you are submitting a refund to MedStar Family Choice.

1. Complete this form and include it with your refund so we can properly apply the check.
2. Use a separate form for each member included on the enclosed refund check.
3. Attach a copy of the original provider voucher, along with additional information that might assist in processing refund.
4. For multiple claims, print the attached spreadsheet with a list of all claim numbers involved.

Important: Before issuing a refund, please verify that the accounts receivable reflected on your provider voucher has not already been satisfied.

Please select one: ☐ Immediate Recoupment of Payment ☐ Refund Check Attached

INFORMATION

Provider/Practice Name:	Date:
Provider TIN:	Date of Service:
Member Name:	Claim #:
Member ID:	Refund Amount:

REASON FOR REFUND

- ☐ Billed in error
- ☐ Returned product (DME/Supplies)
- ☐ COB (If other insurance is primary, please attach the primary EOB)
- ☐ Subrogation/Worker's compensation (please attach document from carrier)
- ☐ Not our patient
- ☐ Processed under wrong NPI (be sure to include correct NPI)
- ☐ Duplicate payment
- ☐ Other (Comments required)

ADDITIONAL COMMENTS

CONTACT INFORMATION

Contact Person:	Contact Phone #:	Contact Email:

Mail to: MedStar Family Choice
5233 King Ave., Suite 400
Baltimore, MD 21237

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This spreadsheet should be used to submit multiple claims on a refund. Please submit spreadsheet with top cover page. Supply all available information to help ensure the proper posting of your check. Additional documentation, such as Remittance Advice (RA) is also helpful and should be submitted if available.

Please be specific when completing the Reason of Overpayment column and make sure your check total equals the claim totals identified. Thank you.

Member ID	Member First Name	Member Last Name	Provider Tax ID #	Claim #	MFC Check #	Service Date	Billed Amount	Refund Amount	Reason for Overpayment