FOR OFFICE USE ONLY:	
Patient Name:	
MCO:	DOS:
Hospital:	Decision:

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MCO/VO Disputed Claims Review Form

Hospitals or their representatives must complete the form and attach the required documents before the Committee will take any action on the case. The Committee will return incomplete forms and will not initiate review until the hospital or their representatives comply.

Hospitals and their representatives must follow the criteria below before submitting their claim:
1) All claims must have gone through the first level of appeal for both Value Options and the patient's MCO; 2) Neither MCO or VO has paid for any portion of the claim; and 3) The dates of service have to be within the past year as of January 2014.

Any claims where everything has been paid except for the psych evaluation need to be sent to the Mental Hygiene Administration Administrative Service Organization (ASO), currently Value Options.

This claims form and the requested attachments should be sent to the following location:
Maryland Department of Health and Mental Hygiene

ATTN: Maryland Claims Review Committee
201 W Preston St
Room 523
Baltimore, MD 21201

(Please note: A completed form has PHI and therefore should be faxed, mailed or sent via secure email)

Hospital Information

Referring Contact: _____ Email: _____

Hospital Name: _____ Phone: _____

Mailing Address: _____

Patient Claim Information

Patient Name: _____ Patient DOB: _____

Patient MA#: _____ Patient MCO: _____

Patient SS#: (if no MA#) _____ Date(s) of Service: _____

Level of Service: _____ Primary Discharge Diagnosis: _____
(ex: ER, inpatient, etc) *(Attach UB04)*

Value Options

Date bill submitted to VO: _____ Remittance advice date: _____

Was any portion of the claim paid? Yes ____ No____ Claim total: _____

If yes, how much was paid: _____ Date of payment: _____

If no, what was denial reason?: _____

_____

Report date of appeal/decision: _____
(Attach all documentation)

Managed Care Organization

Date bill submitted to MCO: _____ Remittance advice date: _____

Was any portion of the claim paid? Yes ____ No____ Claim total: _____

If yes, how much was paid: _____ Date of payment: _____

If no, what was denial reason?: _____

_____

Report date of appeal/decision: _____
(Attach all documentation)

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THIS SECTION IS FOR DHMH USE ONLY

Brief Synopsis of Case:

Discharge Diagnoses on UB04:

Review Decision: