MedStar Family Choice Health Plan
Quick Reference Guide
Effective Date: Oct. 1, 2020

Plan Information

Managed care organization		District of Columbia's Medicaid Managed Care Program, which includes DC Healthy Families Program (DCHFP), DC Healthcare Alliance Program (Alliance), and Immigrant Children's Program (ICP)

Contact Information

Eligibility	**District of Columbia Government Medicaid IVR system:** **1-202-906-8319 (inside DC Metro area)** **1-866-752-9233 (outside DC Metro area)** **District of Columbia website:** **www.dc-medicaid.com**	Prior to rendering services, verify enrollees are assigned to MedStar Family Choice (MFC) and are eligible for benefits.
Authorizations and Claims	**1-800-777-5327**	Call this number for enrollee care inquiries, outpatient preauthorization when required, and higher levels of care preauthorization. You also may view existing authorizations and check claims status after secure sign-in at MagellanProvider.com.
Claims Submission	**www.MagellanProvider.com**	Submit claims electronically either through direct submit, an approved clearinghouse, or Magellan's *Submit a Claim Online* application – available by securely logging in to the Magellan provider website. (Magellan's Payor ID number is 01260.) Be sure to identify the P.O. Box for claims submissions for this plan.
	Paper claims: **Magellan Healthcare** **P.O. Box 2271** **Maryland Heights, MO 63043**	If you do not have Internet access, use the standard CMS-1500 claim form or the UB-04 claim form. Claims must be filed using the HIPAA-compliant CPT code(s).
Claims Status	**1-800-777-5327**	Call this number for claims information. You also may check the status of your claims after secure sign-in at MagellanProvider.com.
Appeals	**www.MagellanProvider.com** **Magellan Appeals** **PO Box 1718** **Maryland Heights, MO 63043** **Phone: 1-800-777-5327** **Fax: 1-888-656-5712**	Submit enrollee, provider and claims appeals to Magellan. If submitting an appeal via the provider website, select *Submit an Appeal/Dispute Document* from the left menu after you sign in.

Complaints and Grievances	**Magellan Complaints and Grievances** **14100 Magellan Plaza** **Maryland Heights, MO 63043** **Phone: 1-800-777-5327** **Fax: 1-888-656-5034**	Submit enrollee and provider complaints and/or grievances to Magellan.
Website	**www.MagellanProvider.com**	Access our website for further information about serving Magellan members, including: • Magellan provider handbook • Medical necessity criteria • Clinical guidelines • Credentialing criteria • Authorizations • Claims submission and status • Appeal/dispute submission form • Provider profile application (to enhance the information members see about you in directories) • Sample PCP communication forms • Provider data change form • Group and facility roster maintenance • Award-winning Magellan provider newsletter, *Provider Focus*
National Provider Services Line	**1-800-788-4005**	Call this number for general inquires, including credentialing and network status, or for any other network administrative issues.
TTY/TDD	**711**	Dial for relay service.

Authorizations

Magellan uses our streamlined clinical management model for outpatient treatment for MedStar Family Choice Health Plan's DC Medicaid enrollees. In this model, for most outpatient cases, providers do not need to preauthorize routine outpatient services or submit treatment request forms for continued care.

For additional information regarding our outpatient model and for requesting higher levels of care, go to www.MagellanProvider.com, select *Providing Care*, then *Initiating Care*, then *Authorization*.

Appeals, Complaints, and Grievance Process

Magellan is delegated for all **enrollee and provider appeals**. An appeal is used when a enrollee or provider disagrees with an initial determination or a revised determination related to the stoppage, reduction or restriction on a previously authorized benefit. Submit within 60 calendar days of the denial letter date. Submit written request, outline the reason for the appeal, and include necessary documentation. Appeal submission options are listed above. Magellan will make a decision about the appeal: 72 hours for expedited and 30 calendar days for standard appeals.

A **claim appeal/dispute** can be filed for a denied claim. Submit within 90 business days of the denial letter date or EOB. Submit written request, outline the reason for the appeal, and include necessary documentation. The claims appeal submission options are listed above. Magellan will make a decision about the appeal within 30 calendar days of receipt of request and notification verbally in writing will be provided.

Magellan will investigate **enrollee and provider complaints and/or grievances**, and you will receive a proposed written resolution. The grievance and complaints submission options are listed above.