MOLINA® HEALTHCARE

Claims Reconsideration Request Form

(Requests must be received within 120 days of date of original remittance advice)

Number of faxed pages (including cover sheet): _____

☐ MyCare Ohio ☐ Marketplace ☐ **Medicaid** Reconsideration ☐ **Medicare** Appeal ☐ Participating ☐ Non-Participating

Please return this complete form and any supporting documentation to: Fax #: (800) 499-3406 Or mail to:
Molina Healthcare of Ohio, Attn: Provider Services, PO BOX 349020, Columbus, OH 43234-9020

PROVIDERS NOTE: Please send Corrected Claims as normal claim submissions via electronic or paper.

Section 1: General Information

Claim Number (One claim per form)		Member Id #	
Member Name		Date of Service	
Provider Name		Billed Charges ($)	Contact Person
Provider ID (TIN)	NPI	Provider Phone #	Provider Fax #

Section 2: Type of Claim Adjustment

Based upon the following reason(s), we are requesting reconsideration of this claim.

Type of Claim Reconsideration/Appeal Provider: Please check applicable reason(s) and attach all supporting documentation.	
☐ **Provider:** Processed under incorrect provider/TAX ID number	☐ **Med Necessity:** Attach reason Prior Authorization was not obtained for service performed & medical records
☐ **CCI Edits:** Attach supporting documentation / medical records (Documentation is required)	☐ **Timely Filing:** Attach claim & supporting documentation showing claim was filed to Molina in a timely manner.
Coordination of Benefits Information: ☐ Alternate Insurance Information / EOP Attached _____ _____ ☐ COB-Related Adjustment Primary Insurance Carrier information: _____ _____ _____ _____	**Payment Amount:** ☐ Claims Reversal Needed- Reason: _____ ☐ Under / Overpayment – Explain the reasoning: _____ ☐ Service is not a duplicate - Explain the reasoning: _____ ☐ Pre-Authorization now on file - # _____
Comments/Other: _____ _____ _____	

For Internal Use Only:
Resolution: _____
_____
For Medicare Use Only - Letter Sent: (circle one) Yes or No Date Letter was sent**:** _____
Date Received: _____ Completed by: _____ Date: _____

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