



MOLINA HEALTHCARE OF NEW MEXICO, INC.
PROVIDER RECONSIDERATION REVIEW REQUEST (PRR) FORM

Please print or type the following information:

Provider's Name: _____ / TIN: _____

Requestors' name and title (if different than above): _____

Address: _____ /Phone: (____) _____

Member's name: _____

Member's ID#/SS#: _____ Date of birth: ____/____/____

SPECIFIC REQUEST: _____
REASON FOR REQUEST _____
Procedure Code(s) in Question: Billed Amount of Procedure: Date of Service:
\$ _____ /____/____
\$ _____ /____/____

ATTACH COPIES OF THE FOLLOWING DOCUMENTS, AS APPLICABLE:

- Contract information.
The original claim(s). If you originally submitted the claim electronically, a hard copy of the claim(s) in question will be needed.
Explanation of benefits form(s).
Correspondence and/or chronology of pertinent events.
Medical records/progress notes and/or operative report to support request.

Instructions

- 1. Print and fill out this form completely, use reverse side if additional space is needed. Describe the issue in as much detail as possible and attach copies of the supporting documentation as applicable.
2. Include a telephone number that you can be reached at during business hours.
3. Return the completed form, within 180 calendar days of Molina Healthcare's notice of action, with your supporting documentation attached, to the address listed below.
4. The PRR review will be completed within 30 days from the date the request is received.

Requestor's Name / Title (if different than provider's name) _____ Date ____/____/____ Telephone Number _____

Mail this form with documentation to:

Molina Healthcare of New Mexico

Attn: Provider Services Department - PRR Request

PO Box 3887, Albuquerque, NM 87190-9859

Telephone - Salud: Albuquerque (505) 341-7493 or toll-free (888) 825-9266

Telephone - SCI & SCI/UNMCI: Albuquerque (505) 348-1578 or toll-free (866) 403-3018