Request for Claim Reconsideration

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

Please print this page as a cover sheet and fax documents to (614) 781-4464 or mail to:

Molina Healthcare of Ohio, Inc.
Attn: Provider Services
P.O. Box 349020
Columbus, OH 43234-9020

Region: ❑ Central ❑ West Central ❑ Southwest ❑ Southeast Number of faxed pages (including cover sheet): ______

Provider Information:

TIN: ______ Rendering Provider Name: ______

Phone: ______ ext: ______ Fax: ______

Submitted by Name: ______ Title: ______

Email: ______

Authorization Information:

Enter Authorization Number (if applicable): ______

Claim Information:

Claim Number: ______ Billed Charges: $ ______ DOS: ______ to ______

Member Name: ______ Member Number: ______

Reason for Request (Please Submit Corrected Claims to Molina Healthcare, Inc. Claims Address): ______

______

______

For Health Plan Use Only:

Date Received: ______ Date of Response: ______ (turnaround within 30 days)

Resolution: ______

______

______

Reviewer's Initials ______

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