



Appeal Representative Form

Member Name: _____

Member Address: _____

City, State Zip: _____

Member ID Number: _____

I _____ appoint _____ to act as my representative in requesting an appeal from Molina Healthcare of Ohio, Inc. regarding the termination, reduction, denial or suspension of medical service coverage.

Practitioners/Providers please note: While this appeal is in process you may not limit the member's access to services.

Member Signature: _____

Date: _____

Please submit to:

Molina Healthcare of Ohio, Inc.
Attn: Appeals Department
P.O. Box 349020
Columbus, Ohio 43234-9020

You may also fax this form to the attention of the Appeals Department at: (614) 781-1410. Please note, if you fax the form, you must also mail the original to the Appeals Department at the address noted above.

Distribution: Original to Molina Healthcare of Ohio
Copy to member
Copy to member's medical record