Claim Status Inquiry Form

Date of Request: _____ Fax to: **(888) 296-7851**

☐ **Medicaid** ☐ **Medicare** ☐ **Marketplace** ☐ **MyCare Ohio**

The Claim Status Inquiry Form is intended for use regarding claims that are over 30 days old.
Inquiries about claims that were submitted less than 30 days ago should not be submitted via this form.

Provider: _____ **Contact:** _____ **Fax:** _____ **Phone:** _____

Provider – Please complete fields below				Molina will complete the fields below and return to requester				
Patient Name	**ID Number**	**DOS**	**Charge**	**Claim Received (Y/N)**	**Claim Status**	**Claim Remit Date**	**Check Number**	**Paid Amount/ Denial Code**

Explanation of Denial:

403750H0414
MHO-1630