Appeal Representative Form

Member Name: _____

Member Address: _____

City, State, Zip: _____

Member ID Number: _____

Denied Service/Date: _____

I appoint _____to request an appeal on my behalf and serve as my representative throughout the appeal process.

Member Signature: _____

Date: _____

Please submit to:

Molina Healthcare, Inc.
ATTN: Grievance and Appeals Department
PO Box 22816
Long Beach, CA 90801-9977

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

You may also fax this form to the attention of the Appeals Department at: (866) 713-1891.

If you have any questions or concerns, please call Member Services at (855) 687-7862. For the hearing impaired, dial 7-1-1 for TTY/Ohio Relay. Representatives are committed to treating you with respect and getting you the help you need. A representative will be available to assist you from 8 a.m. to 8 p.m. Monday through Friday.

Molina Dual Options MyCare Ohio Medicare-Medicaid Plan is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees. You can get this information for free in other languages. Call (855) 687-7862. The call is free. Usted puede recibir esta información en otros idiomas gratuitamente. Llame al (855) 687-7862. Esta es una llamada gratuita. This information is available in other formats such as Braille, large print and audio.

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