Claims Submission
Molina Healthcare of Michigan requires that claims for all Medicaid programs (including Healthy Michigan Plan) are submitted timely and accurately in accordance with federal, state, and applicable contractual requirements.

Providers may submit all claims via:

**Molina Healthcare Provider Portal (Contracted Providers Only):**
https://provider.molinahealthcare.com/

**Electronic Data Interchange (EDI):**
Payer ID: 38334
*If you would like to begin submitting claims via EDI, please contact us at (866) 409-2935*

**Paper Claim***:
("Please do not submit claims to the Troy, Michigan address as your claim may be returned.")

Molina Healthcare
P.O. Box 22668
Long Beach, CA 90801

*Faxed claims are not accepted by Molina Healthcare and if received, the claim will be returned.*

Electronic Claims Submission
Molina Healthcare accepts claims electronically (including secondary claims). Electronic claims submission allows claims to be directly entered into Molina Healthcare’s processing system, which results in faster payment and fewer rejections.

Providers may submit electronic claims via the Molina Healthcare Provider Portal and/or through EDI.

**Paper Claim Submission Guidelines**
- Must use original CMS 1500 or UB04 Claim Forms
- Must be typewritten or computer generated
- Do not use highlighters, white-out or any other markers on the claim
- Avoid script, slanted or italicized type (12 point font is preferred)
- Do not use an imprinter to complete any portion of the claim form
- Do not use punctuation marks or special characters
- Use a six digit format with no spaces or punctuation for all dates (e.g. 060101)
- Securely staple all attachments (attachments should identify patient’s name and recipient ID number)
**Newborn Care**

Newborn care must be submitted on the appropriate claim form using the newborn’s Medicaid ID number. The mother’s Medicaid ID number may not be used to bill for services provided to a newborn.

**D-SNP Dual Eligible Members**

Services provided to members who are covered by both Molina Medicare Options Plus and Molina Medicaid should follow the guidelines below:

Submit one claim to Molina Medicare Options Plus (MMOP). Upon receipt of the claim, the claim will be processed under Molina Medicare Options Plus and then automatically processed by Molina Medicaid.

The claims response will be reported on separate Explanation of Payments (EOP’s). The first will come from Molina Medicare indicating how the claim was processed and informing you that the claim was forwarded to Molina Medicaid for secondary processing. The second EOP will show how the claim was processed by Molina Medicaid, using the same claim number as the MMOP claim but with an “S” on the end to indicate secondary payment by Molina Medicaid.

**Timely Filing of Claims**

Molina Healthcare requests that claims are submitted within 90 days after services are rendered. All claims must be received by Molina Healthcare no later than 365 calendar days (1 year) from the date of service.

Molina Healthcare requires secondary claims to be received within 180 calendar days from the date of the primary carriers Explanation of Payment.

Timely filing limitations are not extended if the provider submits claims to the incorrect payer prior to submitting to Molina Healthcare. All claims received after the Timely Filing period has elapsed will be denied and members cannot be billed for claims that are not submitted timely. Providers have the right to appeal timely filing limitations in the event of extenuating circumstances. Please refer to the Appeals & Grievances section of the Provider Manual for additional information.

**Claim Resubmission**

Molina Healthcare accepts resubmission claims via electronic or paper submission. Providers may submit Replacement of Prior Claim or Corrected Claims through the following process:

**CMS 1500 Claim Forms:**
In Box 22: Medicaid Resubmission Code and the original reference number; input the applicable Medicaid Resubmission Code as well as the original claim number as
Claims

identified on the Explanation of Payment (EOP) and resubmit the claim electronically or via paper.

Medicaid Resubmission Codes:

- 1 - Original (admission through discharge).
- 7 - Replace (replacement/correction of prior claim).
- 8 - Void (void/cancel of prior claim and recoup previously paid dollars).

**UB04 Claim Forms:**
Indicate the applicable bill type in box 4 as well as input the original claim number as identified on the Explanation of Payment (EOP) in box 80 and resubmit the claim electronically or via paper.

**Claims Submission Policy/Provider Responsibilities**

Molina Healthcare complies with all federal, state, and contractual requirements when processing claims. Providers are required to submit clean claims* to Molina Healthcare for processing. Claims not submitted appropriately as clean claims, may be denied and require resubmission. The Claims Policies/Provider Responsibilities identified below are to provide a reference to submitting claims for processing.

(*A clean claim is considered a UB04 or CMS1500 form with appropriate ICD-9/ICD-10 and CPT/HCPCS codes for the services rendered and as defined by MCL 400.111i.)

Providers must (in good faith) bill Molina Healthcare for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility claims, the date of discharge.

**NPI Requirements**

Contracted and Non-Contracted Providers are required to obtain and provide their National Identification Number (NPI) on all claims submitted to Molina Healthcare. The table below outlines NPI submission requirements for the CMS 1500 and UB04 claim forms.

<table>
<thead>
<tr>
<th>CMS 1500</th>
<th>Required?</th>
<th>Field Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider NPI</td>
<td>Yes</td>
<td>Box 33a</td>
</tr>
<tr>
<td>Billing Provider Medicaid Number</td>
<td>Yes</td>
<td>Box 33b</td>
</tr>
<tr>
<td>Rendering Provider NPI</td>
<td>Yes</td>
<td>Box 24j</td>
</tr>
</tbody>
</table>
Rendering Provider Medicaid Number | Yes | Box 24j
---|---|---
Referring Provider NPI | If Applicable | Box 17b
Facility Provider NPI | If Applicable | Box 32a
Taxonomy Code | No | Boxes 24j; 33b and 32b

<table>
<thead>
<tr>
<th>UB04</th>
<th>Required?</th>
<th>Field Location</th>
</tr>
</thead>
<tbody>
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<td>Box 56</td>
</tr>
<tr>
<td>Billing Provider Medicaid Number</td>
<td>Yes</td>
<td>Box 57a</td>
</tr>
<tr>
<td>Attending Provider NPI</td>
<td>If Applicable</td>
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</tr>
<tr>
<td>Operating Provider NPI</td>
<td>If Applicable</td>
<td>Box 77j</td>
</tr>
<tr>
<td>Other Provider NPI</td>
<td>If Applicable</td>
<td>Box 78</td>
</tr>
<tr>
<td>Other Provider NPI</td>
<td>If Applicable</td>
<td>Box 79</td>
</tr>
<tr>
<td>Taxonomy Code</td>
<td>No</td>
<td>Boxes 57, 76, 77, 78 and 79</td>
</tr>
</tbody>
</table>

**Compensation**

Contracted providers will be compensated according to the terms of the agreement between the provider and Molina Healthcare applicable on the date of services rendered. **Non-Contracted** providers will be compensated for covered services in accordance with the MDHHS Medicaid fee schedule in effect on the date of services rendered or as otherwise agreed upon by Molina Healthcare.

**Coordination of Benefits**

As a provider treating Molina Healthcare members, your cooperation in notifying Molina Healthcare when any other coverage exists is appreciated. This includes other health care plans or any other permitted methods of third party recovery for coordination of benefits, worker’s compensation and subrogation.

- Claims involving coordination of benefits with primary insurance carriers should be received by Molina Healthcare within 180 days from the date of the primary carrier’s explanation/denial of benefits.
- If Molina Healthcare reimburses a provider and then discovers other coverage is primary, Molina Healthcare will recover the amount paid by Molina Healthcare.
- Regardless of the primary payer’s reimbursement, Molina Healthcare should be billed as a secondary payer for all services rendered. A copy of the primary payer’s EOP showing payment or denial must be attached to the claim when submitting payment, or the claim can be submitted electronically for secondary coordination.
- The claims core processing system is configured according to MDHHS guidelines. This method calculates what Molina Healthcare of Michigan (MHM) would pay as primary and subtracts the primary carrier’s payment.
from this amount. The MHM payment is the lesser of this difference, or the Medicaid allowable per line. In other words, we can pay up to the patient responsibility, but **never more than** the MHM allowable.

- Molina Healthcare members **cannot be** billed for any outstanding balance after Molina Healthcare makes payment and/or denial.
- Molina Healthcare members do not have deductibles, co-pays or co-insurance with the exception of Healthy Michigan Plan members.
  - All co-pays for Healthy Michigan Plan members will be collected by MDHHS in collaboration with MI ENROLLS. Providers should **not** collect co-pays at the time of services rendered.

**Interim Billing**

Molina Healthcare does not accept claims billed with an interim bill type for outpatient services, containing a 2, 3, or 4 in the third digit. All claims must be billed with the "admit through discharge" information. In the case of continuing or repetitive care, such as with physical therapy, facilities must bill on a monthly basis with all services occurring billed on one claim, with service from and to dates listed separately per line, and as an admit through discharge bill.


**Claims Inquiry**

Molina Healthcare complies with all prompt payment federal, state, and contractual regulations. All claim submissions are responded to via an Explanation of Payment (EOP). If you have not received a response within 45 days of claim submission, you are encouraged to contact Molina Healthcare to status your claim.

You may inquire on the processing of your claim on the Molina Healthcare Provider Portal at [https://provider.molinahealthcare.com/](https://provider.molinahealthcare.com/) or by contacting the Provider Contact Center at (855) 322-4077, Monday – Friday 8:00 a.m. – 5:00 p.m. EST.

When contacting the Provider Contact Center, please have the Member ID, Member Demographic Information; Date of Service; Claim Billed Amount; and the Tax ID and/or NPI available to ensure timely assistance.

**Claims Appeals/Disputes**

For information on submitting an appeal or dispute, please refer to the Appeals and Grievances section of the Molina Healthcare of Michigan Provider Manual.