MOLINA HEALTHCARE OF NEW MEXICO, INC.
PROVIDER RECONSIDERATION REVIEW REQUEST (PRR) FORM

Please print or type the following information:

Provider's Name:_____/ TIN:_____

Requestors' name and title (if different than above): _____

Address: _____/Phone: (____) _____ _____

Member's name: _____

Member's ID#/SS#: _____ Date of birth: _____/_____/_____

CLAIM NUMBER (One claim per form): _____

REASON FOR REQUEST _____

Procedure Code(s) in Question:	**Billed Amount of Procedure:**	**Date of Service:**
_____	$_____	_____/_____/_____
_____	$_____	_____/_____/_____

ATTACH COPIES OF THE FOLLOWING DOCUMENTS, AS APPLICABLE:

- ☐ Contract information.
- ☐ The original claim(s). If you originally submitted the claim electronically, a hard copy of the claim (s) in question will be needed.
- ☐ Explanation of benefits form(s).
- ☐ Correspondence and/or chronology of pertinent events.
- ☐ Medical records/progress notes and/or operative report to support request.

Instructions

1. Print and fill out this form completely, use reverse side if additional space is needed. Describe the issue in as much detail as possible and attach copies of the supporting documentation as applicable.
2. Include a telephone number that you can be reached at during business hours.
3. Return the completed form, within 90 calendar days of Molina Healthcare's orginal remittance advice , to the fax number listed below.
4. The PRR review will be completed within 30 days from the date the request is received.

_____ ____/____/___ _____
Requestor's Name / Title (if different than provider's name) Date Telephone Number

Fax this form with documentation to (855) 378-3642
Telephone Albuquerque (505) 341-7493 or toll-free (888) 825-9266