Claim Status Inquiry Form

MOLINA HEALTHCARE

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

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:** _____

CONFIDENTIALITY NOTICE: This communication, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this communication is prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents.

| 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: