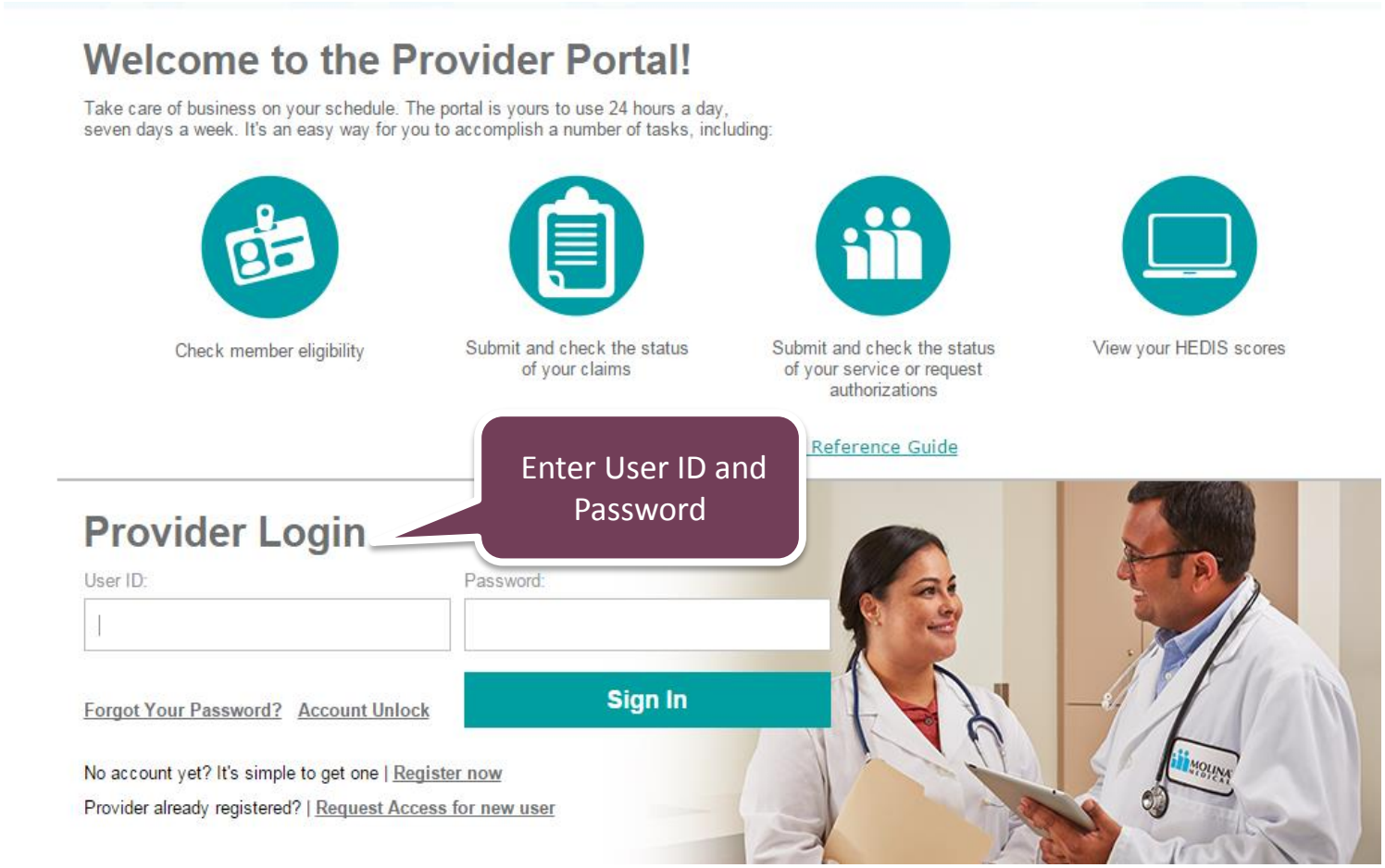
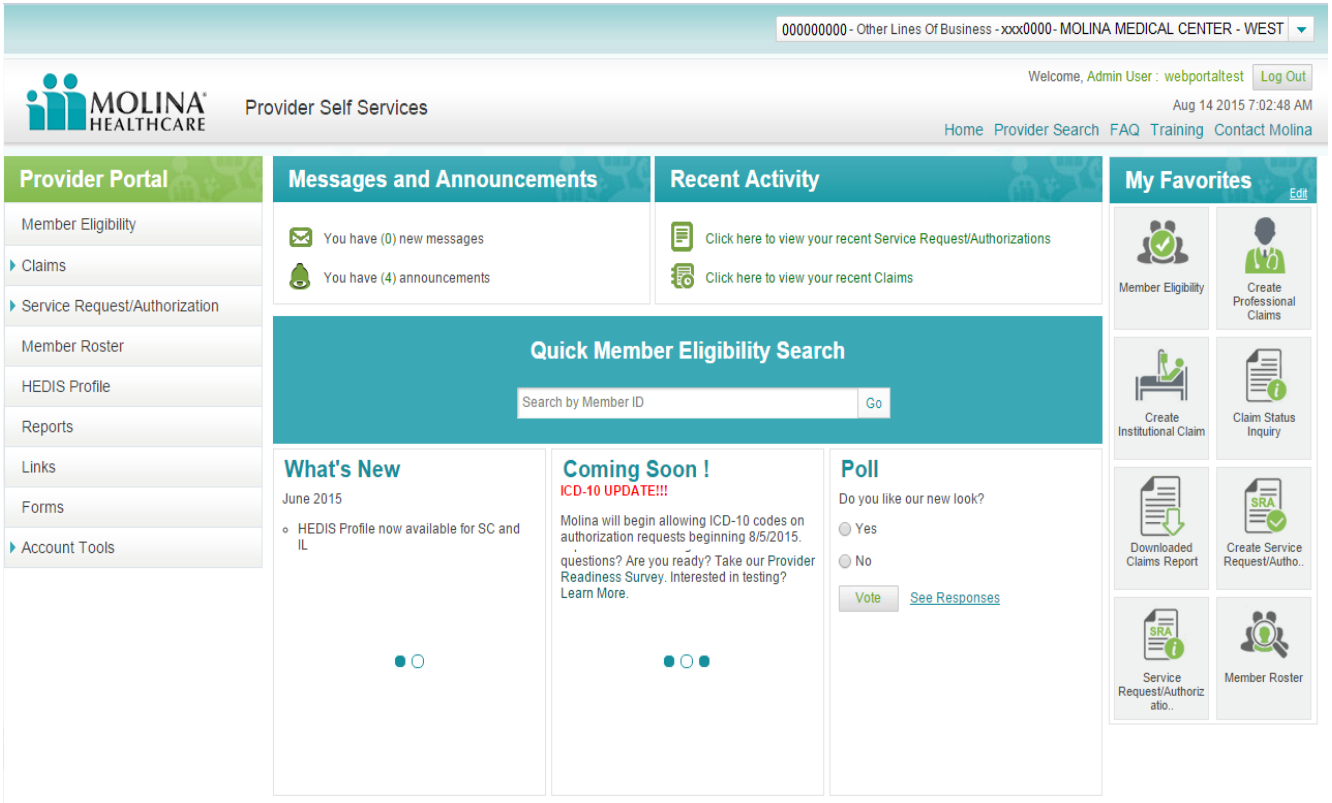
Provider Appeal Request Form



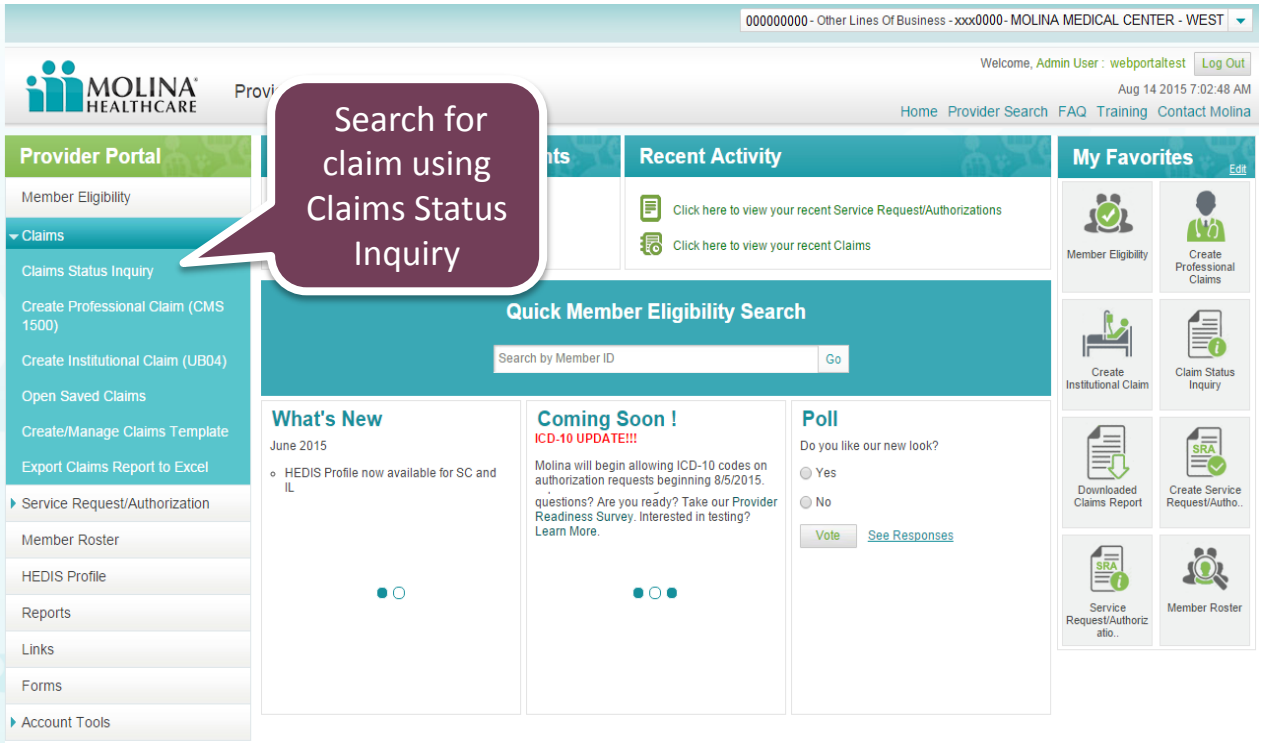
Provider Appeal Request Form

Once the provider has successfully logged in, they will be to routed to the Provider Portal home page.

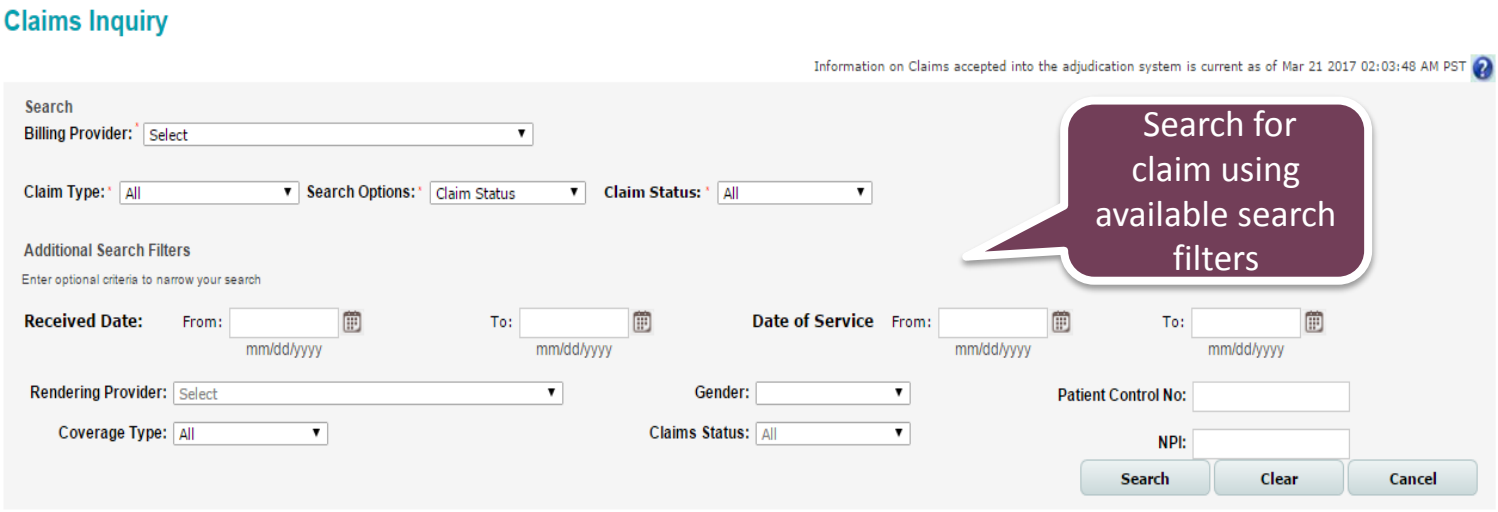


Provider Appeal Request Form

By selecting the Claims Status Inquiry feature, the provider may search for the claim that they would like to appeal.



Provider Appeal Request Form



The provider may search for the desired claim using any of the available search filters (claim status, claim number, dates of service, etc.)

Provider Appeal Request Form

Claims Found

Click on an underlined column header to sort or hover over a ? for help with that column

Claim ID	Member Name	Billed Amt	Service Date From	Service Date To	Received Date	Submission Type*	Status	Status Date	Claim Type	Attachments
						Select	Select		Select	
0101010101		.00	03/21/2017	03/21/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
1111222333		.00	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
9876543210		.24	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
0123456789	SMITH, JOHN	2,167.00	09/14/2016	09/14/2016	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
1111111111	DOE, JANE	8,161.00	10/15/2016	10/15/2016	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
2222222222	SMITH, JOHN	3,363.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
3333333333	SMITH, JOHN	3,447.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
4444444444	DOE, JANE	5,235.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
5555555555	DOE, JANE	3,420.00	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
7777777777	SMITH, JOHN	5,832.24	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	

1 2 3 4 ... Page 1 of 10 10 per page Showing 1-10 of 100

Select claim ID for desired claim

Print

*Submission Types are only applicable to claims submitted via Web Portal.

Once the search results display, the provider will need to click on the desired claim ID to access the claim details.

Provider Appeal Request Form

Claim Details

General Information

Member Name: EVERDEEN, KATNISS
Claim Status Category:
Claim Header Status: Denied
Rendering Provider Name: MOLINA MEDICAL
Rendering Provider NPI: 111111111
Check Paid Date: 03/14/2016
Service Date To: 8/31/2015

Claim Number: 1010101010
Claim Status Effective: 8/31/2015
Billed Amount($): 68.00
Check Number:
Service Date From: 8/31/2015
Patient Control Number: 222222222
Amount Paid($): 0.00

Claim Line Items

Claim Line	Service From Date	Service To Date	Rev Code	Service Code	Modifiers	Units	Billed Amt	ine Status Effective	Status	Remit Message
1	08/31/2015	08/31/2015		99232		1	68.00	8/31/2015	No Payment will be made for this claim line	Claim denied charges.

Showing 1-1 of 1 | 10 per page | Page 1 of 1

Select "Appeal Claim" button

Save As Template | Appeal Claim | Void Claim | Correct Claim | View Diagnosis Code | Print Claim Summary | Back

- Once routed to the Claim Details page, the provider can access the Provider Appeal Request Form by selecting the "Appeal Claim" button.
- Note: The "Appeal Claim" button will only be available for finalized (paid, denied, etc.) claims.

Provider Appeal Request Form

The Provider Appeal Request Form will then display with the following information auto-populated:

1. Provider Name
2. NPI
3. Federal ID
4. Claim Number
5. Date of Service
6. Total Billed Charges
7. Address
8. City/State/Zip
9. Member ID
10. Member Name
11. Date of Birth
12. Submission Date
13. Receipt Date

Provider Appeal Request Form

Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	111111111	Federal ID:*	222222222
Request Type:	Appeal	Participation Status:	(•) Contract ( ) Non - Contracted		
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	3333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Choose File No file chosen Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Submitter Name:*		Submission Date:	07/13/2017	Receipt Date:	07/13/2017

Appeals submitted after 5pm are considered to be received on the following business day. The receipt date will be captured once the submit button has been selected.

☐ By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.*

Print Submit Cancel

Provider Appeal Request Form

- All populated data can be updated by backspacing and typing the correct info into the field.
- All fields with the exception of *Member ID, Member Name, DOB, and Email Address* are editable.
- The Submission Date & Receipt Date are populated based on the time zone of the logged in provider. These values are set and cannot be changed.

Provider Appeal Request Form

Instructions for filing an Appeal:

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2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	111111111	Federal ID:*	222222222
Request Type:	Appeal	Participation Status:	(•) Contract ( ) Non - Contracted		
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	3333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

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File : Choose File No file chosen Upload

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Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Submitter Name:*		Submission Date:	07/13/2017	Receipt Date:	07/13/2017

Appeals submitted after 5pm are considered to be received on the following business day. The receipt date will be captured once the submit button has been selected.

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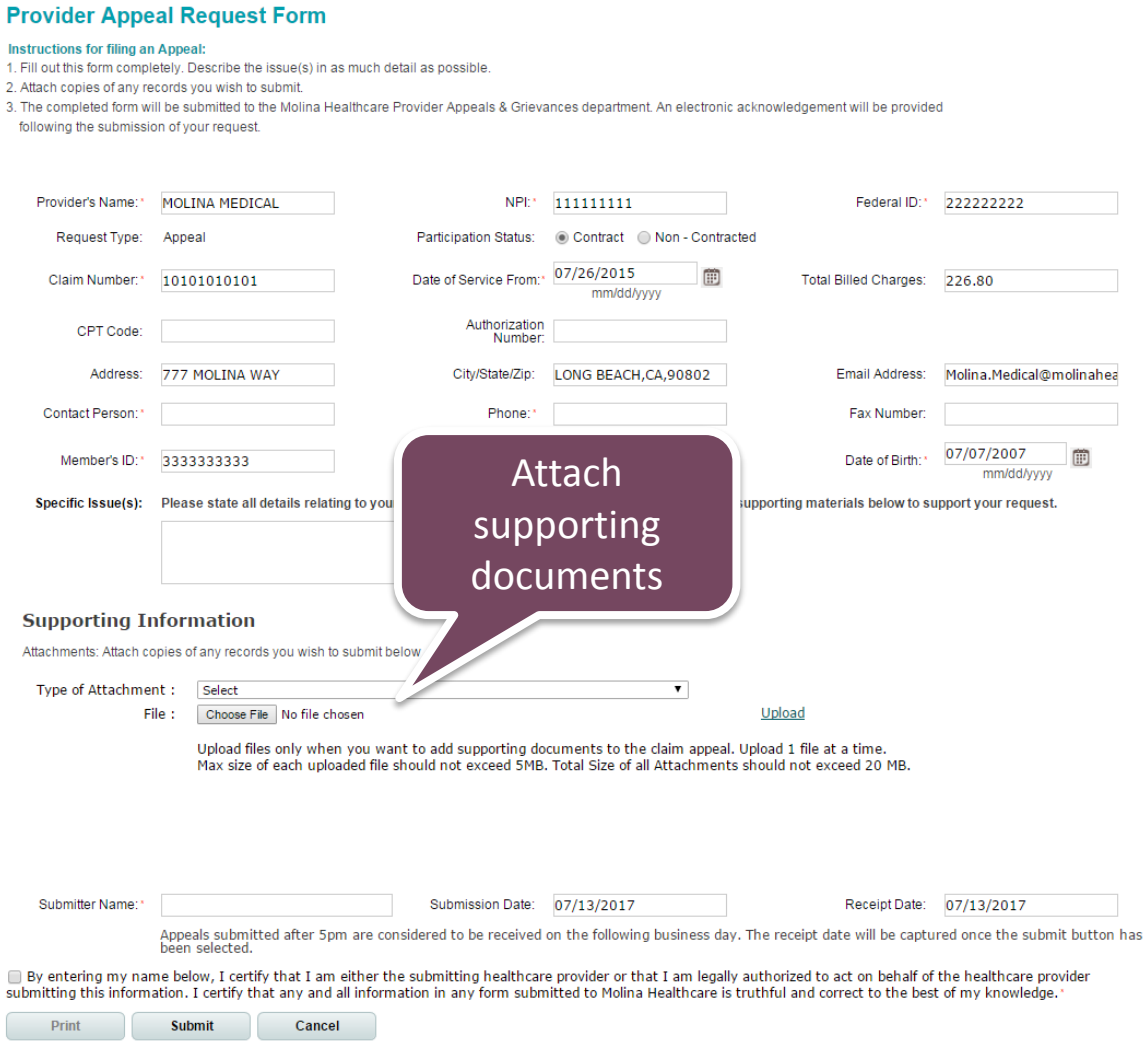
Print Submit Cancel

Provider Appeal Request Form

- The provider may attach any supporting documents that are related to the appeal request.
- Maximum file size is 5MB for individual files, and 20MB for the total size of all attachments.
- Attachments must be submitted in one of the following formats: *.tif, .gif, .pdf, .bmp, or .jpg.*
- Attachments can be uploaded by using the *Supporting Information* section.



Provider Appeal Request Form

Once all fields have been completed and attachments made, the provider will need to agree to the terms and conditions by typing their name into the *Submitter Name* field.

Provider Appeal Request Form

Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	111111111	Federal ID:*	222222222
Request Type:	Appeal	Participation Status:	Contract / Non - Contracted		
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	3333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Choose File No file chosen Upload

Upload files only when you … peal. Upload 1 file at a time.
Max size of each uploaded fil… ents should not exceed 20 MB.

Enter submitter name

Submitter Name:*		Submission Date:	07/13/2017	Receipt Date:	07/13/2017

Appeals submitted after 5pm are considered to be received on the following business day. The receipt date will be captured once the submit button has been selected.

By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.*

Print Submit Cancel

Provider Appeal Request Form

The check box next to the disclaimer at the bottom of the form will also need to be selected.

Provider Appeal Request Form

Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	111111111	Federal ID:*	222222222
Request Type:	Appeal	Participation Status:	(•) Contract ( ) Non - Contracted		
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	3333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Choose File No file chosen Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Submitter … Submission Date: 07/13/2017 Receipt Date: 07/13/2017

…d to be received on the following business day. The receipt date will be captured once the submit button has

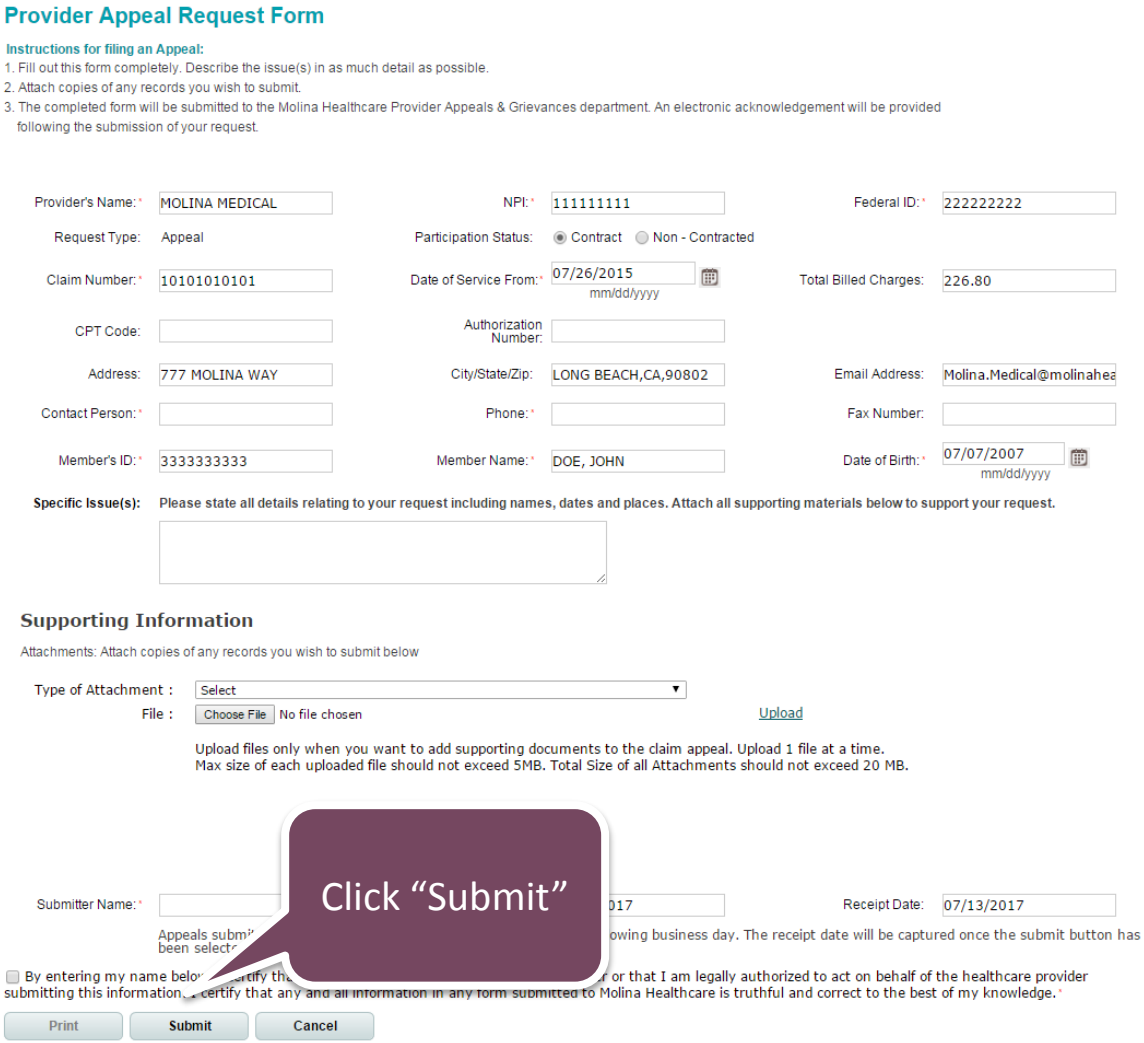
Check Box

☐ By entering my … submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.*

Print Submit Cancel

Provider Appeal Request Form

The Provider Appeal request is considered complete once the “Submit” button has been selected at the bottom of the form



Waiver of Liability Form

- **The following verbiage will display in the Supporting Information section when a Medicare or MMP provider selects *non-contracted* as the participation status:**

  For non-contracted Medicare and MMP providers: please complete and attach the Waiver of Liability along with your appeal.

Provider Appeal Request Form

Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Select participation status

NPI:* 111111111 | Federal ID:* 222222222

Participation Status: Contract / Non - Contracted

Date of Service From:* 07/26/2015 mm/dd/yyyy | Total Billed Charges: 226.80

Authorization Number:

Address: 777 MOLINA WAY | City/State/Zip: LONG BEACH,CA,90802 | Email Address: Molina.Medical@molinahea

Contact Person:* | Phone:* | Fax Number:

Member's ID:* 3333333333 | Member Name:* DOE, JOHN | Date of Birth:* 07/07/2007 mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Choose File No file chosen Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

For non-contracted Medicare and MMP providers: please complete and attach the Waiver of Liability along with your appeal.

Submitter Name:* | Submission Date: 07/13/2017 | Receipt Date: 07/13/2017

Appeals submitted after 5pm are considered to be received on the following business day. The receipt date will be captured once the submit button has been selected.

By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.*

Print | Submit | Cancel

Waiver of Liability Form

Selection of the *Waiver of Liability* link will route the provider to the Waiver of Liability Form.

Provider Appeal Request Form

Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	111111111	Federal ID:*	222222222
Request Type:	Appeal	Participation Status:	○ Contract ◉ Non - Contracted		
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	3333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy

Specific Issue(s): **Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.**

Select Waiver of Liability link

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment : Select

File : Choose File No file chosen Upload

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a tim
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed MB.

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Submitter Name:*		Submission Date:	07/13/2017	Receipt Date:	07/13/2017

Appeals submitted after 5pm are considered to be received on the following business day. The receipt date will be captured once the submit button has been selected.

☐ By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.*

Print Submit Cancel

Waiver of Liability Form

- Once the Waiver of Liability link is selected, the Waiver of Liability Form will display in a new window.
- The provider will need to print, scan, and save the form to their computer in order to attach the document to the appeal along with all other supporting documents.

Appendix 7 - Waiver of Liability Statement
(Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

WAIVER OF LIABILITY STATEMENT

_____
Medicare/HIC Number

_____
Enrollee's Name

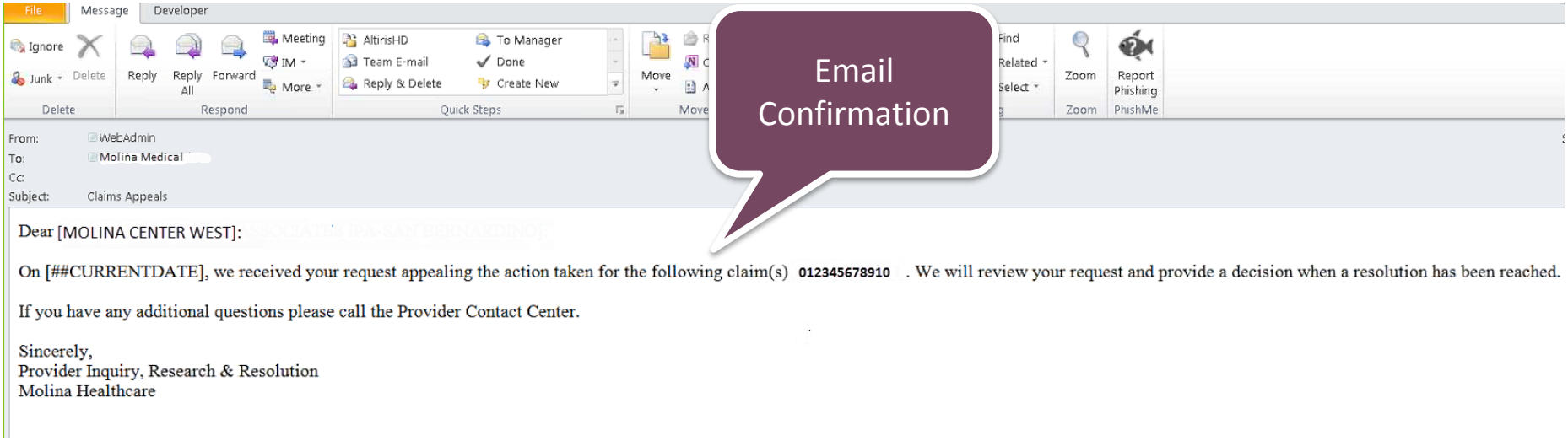
_____ _____
Provider Dates of Service

_____
Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

_____ _____
Signature Date

Email Confirmation



- Upon submission, providers will receive an email confirmation which will serve as an electronic acknowledgement letter for the provider.
- Verbiage in the acknowledgement letter will display differently for California providers.

Email Confirmation

You have received a secure message

Read your secure message by opening the attachment, securedoc.html. You will be prompted to open (view) the file or save (downlo save the file first, then open it in a Web browser. To access from a mobile device, forward this message to mobile@res.cisco.com to receive a mobile login URL.

If you have concerns about the validity of this message, contact the sender directly.
First time users - will need to register after opening the attachment. For more information, click the following Help link.
Help - https://res.cisco.com/websafe/help?topic=RegEnvelope
About Cisco Registered Email Service - https://res.cisco.com/websafe/about

Secure email message

- All email confirmations will be sent in a secure format.
- Upon receipt of the message, the provider will be prompted to do a one time registration with their email address to view the message. A password will be required for all messages received thereafter.