

Provider Appeal Request Form



Welcome to the Provider Portal!

Take care of business on your schedule. The portal is yours to use 24 hours a day, seven days a week. It's an easy way for you to accomplish a number of tasks, including:



Check member eligibility



Submit and check the status of your claims



Submit and check the status of your service or request authorizations



View your HEDIS scores

[Reference Guide](#)

Enter User ID and Password

Provider Login

User ID:

Password:

[Forgot Your Password?](#) [Account Unlock](#)

[Sign In](#)

No account yet? It's simple to get one | [Register now](#)

Provider already registered? | [Request Access for new user](#)



Provider Appeal Request Form



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

000000000 - Other Lines Of Business - xxx0000 - MOLINA MEDICAL CENTER - WEST

MOLINA HEALTHCARE Provider Self Services Welcome, Admin User : webportaltest [Log Out](#)
Aug 14 2015 7:02:48 AM
[Home](#) [Provider Search](#) [FAQ](#) [Training](#) [Contact Molina](#)

Provider Portal	Messages and Announcements	Recent Activity	My Favorites <small>Edit</small>
<ul style="list-style-type: none">Member Eligibility▶ Claims▶ Service Request/AuthorizationMember RosterHEDIS ProfileReportsLinksForms▶ Account Tools	<ul style="list-style-type: none"> You have (0) new messages You have (4) announcements	<ul style="list-style-type: none"> Click here to view your recent Service Request/Authorizations Click here to view your recent Claims	<ul style="list-style-type: none"> Member Eligibility Create Professional Claims Create Institutional Claim Claim Status Inquiry Downloaded Claims Report Create Service Request/Author... Service Request/Authorizatio... Member Roster
<h3>Quick Member Eligibility Search</h3> <p>Search by Member ID <input type="text"/> Go</p>			
	<h3>What's New</h3> <p>June 2015</p> <ul style="list-style-type: none">o HEDIS Profile now available for SC and IL	<h3>Coming Soon !</h3> <p>ICD-10 UPDATE!!!</p> <p>Molina will begin allowing ICD-10 codes on authorization requests beginning 8/5/2015. questions? Are you ready? Take our Provider Readiness Survey. Interested in testing? Learn More.</p>	<h3>Poll</h3> <p>Do you like our new look?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p>Vote See Responses</p>

Provider Appeal Request Form



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

000000000 - Other Lines Of Business - xxx0000 - MOLINA MEDICAL CENTER - WEST

Welcome, Admin User : webportaltest [Log Out](#)
Aug 14 2015 7:02:48 AM
[Home](#) [Provider Search](#) [FAQ](#) [Training](#) [Contact Molina](#)

Provider Portal

- Member Eligibility
- Claims
 - Claims Status Inquiry**
 - Create Professional Claim (CMS 1500)
 - Create Institutional Claim (UB04)
 - Open Saved Claims
 - Create/Manage Claims Template
 - Export Claims Report to Excel
- Service Request/Authorization
- Member Roster
- HEDIS Profile
- Reports
- Links
- Forms
- Account Tools

Recent Activity

- Click here to view your recent Service Request/Authorizations
- Click here to view your recent Claims

My Favorites

- Member Eligibility
- Create Professional Claims
- Create Institutional Claim
- Claim Status Inquiry
- Downloaded Claims Report
- Create Service Request/Author...
- Service Request/Authorizatio...
- Member Roster

Quick Member Eligibility Search

Search by Member ID

What's New

June 2015

- HEDIS Profile now available for SC and IL

Coming Soon !

ICD-10 UPDATE!!!

Molina will begin allowing ICD-10 codes on authorization requests beginning 8/5/2015. questions? Are you ready? Take our Provider Readiness Survey. Interested in testing? [Learn More.](#)

Poll

Do you like our new look?

Yes

No

[See Responses](#)

Provider Appeal Request Form



Claims Inquiry

Information on Claims accepted into the adjudication system is current as of Mar 21 2017 02:03:48 AM PST ?

Search

Billing Provider:

Claim Type: Search Options: Claim Status:

Additional Search Filters

Enter optional criteria to narrow your search

Received Date: From: To: Date of Service From: To:

Rendering Provider: Gender:

Coverage Type: Claims Status: Patient Control No: NPI:

Search for claim using available search filters

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

<u>Claim ID</u> 	<u>Member Name</u> 	Billed Amt	Service Date From	Service Date To	Received Date	Submission Type*	Status	Status Date	Claim Type	Attachments
<input type="text"/>						Select ▼	Select ▼		Select ▼	
<u>0101010101</u>		00	03/21/2017	03/21/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>11112222333</u>		00	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>9876543210</u>		4.24	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>0123456789</u>	SMITH, JOHN	2,167.00	09/14/2016	09/14/2016	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>1111111111</u>	DOE, JANE	8,161.00	10/15/2016	10/15/2016	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>2222222222</u>	SMITH, JOHN	3,363.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>3333333333</u>	SMITH, JOHN	3,447.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>4444444444</u>	DOE, JANE	5,235.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>5555555555</u>	DOE, JANE	3,420.00	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
<u>7777777777</u>	SMITH, JOHN	5,832.24	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	

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 **FILED**
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	Line 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

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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:*	<input type="text" value="MOLINA MEDICAL"/>	NPI:*	<input type="text" value="111111111"/>	Federal ID:*	<input type="text" value="222222222"/>
Request Type:	Appeal	Participation Status:	<input checked="" type="radio"/> Contract <input type="radio"/> Non - Contracted		
Claim Number:*	<input type="text" value="10101010101"/>	Date of Service From:*	<input type="text" value="07/26/2015"/>	Total Billed Charges:	<input type="text" value="226.80"/>
			mm/dd/yyyy		
CPT Code:	<input type="text"/>	Authorization Number:	<input type="text"/>		
Address:	<input type="text" value="777 MOLINA WAY"/>	City/State/Zip:	<input type="text" value="LONG BEACH,CA,90802"/>	Email Address:	<input type="text" value="Molina.Medical@molinahee"/>
Contact Person:*	<input type="text"/>	Phone:*	<input type="text"/>	Fax Number:	<input type="text"/>
Member's ID:*	<input type="text" value="333333333"/>	Member Name:*	<input type="text" value="DOE, JOHN"/>	Date of Birth:*	<input type="text" value="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 :

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: Receipt Date:

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.*

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.

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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@molinahec
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy

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Submitter Name:*

Submission Date: 07/13/2017

Receipt Date: 07/13/2017

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- ❖ 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.

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CPT Code:	<input type="text"/>	Authorization Number:	<input type="text"/>		
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Contact Person:*	<input type="text"/>	Phone:*	<input type="text"/>	Fax Number:	<input type="text"/>
Member's ID:*	<input type="text" value="333333333"/>	Date of Birth:*	<input type="text" value="07/07/2007"/>		
Specific Issue(s):	Please state all details relating to your appeal. Attach supporting materials below to support your request.				



Supporting Information

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

Type of Attachment :

File : No file chosen [Upload](#)

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Request Type:	Appeal	Participation Status:	<input checked="" type="radio"/> Contract <input type="radio"/> Non - Contracted		
Claim Number:*	<input type="text" value="10101010101"/>	Date of Service From:*	<input type="text" value="07/26/2015"/>	Total Billed Charges:	<input type="text" value="226.80"/>
CPT Code:	<input type="text"/>	Authorization Number:	<input type="text"/>		
Address:	<input type="text" value="777 MOLINA WAY"/>	City/State/Zip:	<input type="text" value="LONG BEACH,CA,90802"/>	Email Address:	<input type="text" value="Molina.Medical@molinahea"/>
Contact Person:*	<input type="text"/>	Phone:*	<input type="text"/>	Fax Number:	<input type="text"/>
Member's ID:*	<input type="text" value="333333333"/>	Member Name:*	<input type="text" value="DOE, JOHN"/>	Date of Birth:*	<input type="text" value="07/07/2007"/>

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 :

File : No file chosen [Upload](#)

Upload files only when you are logged in. Max size of each uploaded file is 20 MB. Upload 1 file at a time. Attachments should not exceed 20 MB.

Submitter Name: Submission Date: Receipt Date:

Enter submitter name

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.*

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.



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Request Type:	Appeal	Participation Status:	<input checked="" type="radio"/> Contract <input type="radio"/> Non - Contracted		
Claim Number:*	<input type="text" value="101010101"/>	Date of Service From:*	<input type="text" value="07/26/2015"/>	Total Billed Charges:	<input type="text" value="226.80"/>
			mm/dd/yyyy		
CPT Code:	<input type="text"/>	Authorization Number:	<input type="text"/>		
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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 :

File : No file chosen

[Upload](#)

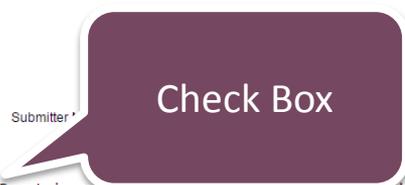
Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Submitter: Submission Date: Receipt Date:

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





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

Provider's Name:*	<input type="text" value="MOLINA MEDICAL"/>	NPI:*	<input type="text" value="111111111"/>	Federal ID:*	<input type="text" value="222222222"/>
Request Type:	Appeal	Participation Status:	<input checked="" type="radio"/> Contract <input type="radio"/> Non - Contracted		
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			mm/dd/yyyy		
CPT Code:	<input type="text"/>	Authorization Number:	<input type="text"/>		
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Submitter Name: * Receipt Date:

Appeals submitted on following business day. The receipt date will be captured once the submit button has been selected.

By entering my name below, I certify that any information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.





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.

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Select participation status

NPI: Federal ID:

Participation Status: Contract Non - Contracted

Date of Service From: Total Billed Charges:

Authorization Number:

Address: City/State/Zip: Email Address:

Contact Person: Phone: Fax Number:

Member's ID: Member Name: Date of Birth:

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

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Waiver of Liability Form

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

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

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Type of Attachment :

File : No file chosen

[Upload](#)

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Select Waiver of Liability link



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

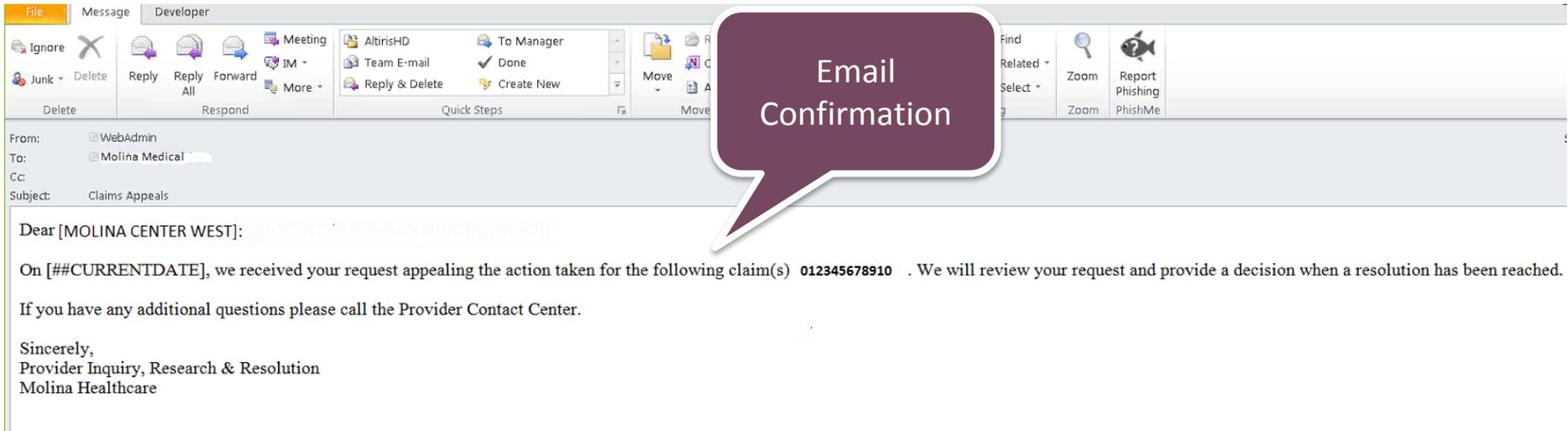
I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

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 (download) the file 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

save the file first, then open it

- ❖ 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.