IMPORTANT!

Molina Provider News:

Claim Submission Tip Sheet

Claims may be submitted:

- Online:
  Availity Portal at https://availity.com/molinahealthcare.

- Via a clearinghouse, **Payer ID #51062**
- On paper to:

Molina Healthcare – Medicaid & Marketplace
PO Box 22812
Long Beach, CA 90801

Molina Healthcare – Medicare
PO Box 22811
Long Beach, CA 90801

Molina Medicaid and Marketplace claims must be submitted by to Molina within six (6) months after the discharge for inpatient services or the date of service for outpatient services. When Molina is secondary, claims, whether paper or electronic, must be submitted within 90 days from the final determination by the primary insurance carrier. If Medicare is the primary carrier, claims must be submitted to Molina within 36 months from discharge or 1(one) year from Medicare's determination, whichever is later.

Molina Medicare claims must be submitted to Molina with one (1) calendar year after the discharge date for inpatient services or the date of service for outpatient services. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit claims to Molina within one calendar year after final determination by the primary payer.

Except as otherwise provided by Law or provided by Government Program requirements, any claims that are not submitted to Molina within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Before filing a claim, please review the following:

- Member eligibility and ID#
- Claim's timely filing
- Primary versus secondary insurance
- Patient liability has been confirmed through DCF documentation or the DCF website
- Rendered services are covered
- Rendered services were authorized (if applicable)

Whether paper or electronic, the following information must be included on every Claim:

- Member name, date of birth and Molina Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers

- Total billed charges
- Place and type of service code
- Days or units, as applicable
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI)
- Rendering Provider name as applicable
- Billing/Pay-to Provider name and billing address
- Billing/Pay-to Provider Zipcode+4 (as registered on the Medicaid portal)
- Billing/Pay-to Provider Taxonomy (as registered on the Medicaid portal)
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans and submission of remittance advice from primary payer
- Explanation of payment for crossover claims
- E-signature
- Service Facility Location information

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the claim.

Services are **not** reimbursed when any of the following apply:

- Services does not meet medical necessity criteria
- Authorization was not obtained for a service requiring prior authorization
- Member is not active at the time services were rendered
- Services duplicate another provider's service

For additional information on claims submission, please visit our website at www.molinahealthcare.com and review our provider handbook. Providers may also call Molina Healthcare at 866-472-4585.

Thank you for your continued care to our Members!

Molina Healthcare of Florida