MOLINA HEALTHCARE

Provider Early Reversal Permission Form

Provider is requesting Molina Healthcare deduct the claim(s) paid in error from a future Remittance

Provider Name _____ Provider Tax ID Number _____

Person Requesting Claim(s) Reversal _____ Signature / Date _____

Claim Number	Overpayment Amount	Overpayment Reason

Comments:_____

_____

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Please fax to Molina Healthcare Claims Recovery Department: (712) 560-3821