Purpose: This form is for all providers disputing a claim with Molina Healthcare of Iowa and serving members in the state of Iowa. Requests must be received within 180 calendar days of date of original remittance advice. Please allow 60 calendar days to process this reconsideration request. Please submit this completed form and any supporting documentation to Molina Healthcare of Iowa.

Availity Portal: Providers are strongly encouraged to use Molina's Provider Portal to submit claim disputes: availity.com/molinahealthcare
Fax: The Claims Dispute Request Form can be faxed to Molina at **(855) 275-3082**. The fax must include the Claims Dispute Request Form. **Email:** Iowaproviderinquiry@molinahealthcare.com
Mail: Molina Healthcare, Inc., C/O Firstsource, 1232 Premier Dr., Suite 100, Chattanooga, TN 37421

Note: Please refer to the corrected claims form for submission guidelines on claims being corrected and not disputed.
**Number of faxed pages (including cover sheet):_____

☐ Participating ☐ Not Participating

Provider's Name: _____ NPI: _____ Federal ID:_____

Claim Number: _____ DOS:_____ Total Charges:_____
(one claim per form)

Address: _____ City/State/Zip:_____

Contact Person:_____ Phone:_____

Member's ID #: _____ Member Name:_____ DOB:_____

Based upon the following reason(s), we are requesting reconsideration of this claim.

Category of Claim Dispute **Provider: Please check applicable reason(s) and attach supporting documentation.**	
☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider/tax ID number
☐ **Coding/Bundling Edits:** Attach supporting documentation/medical records (Documentation is required)	☐ **Timely Filing:** Attach claims & supporting documentation showing claim was filed to Molina in a timely manner
☐ **Coordination of Benefits Information:** Alternate Insurance Information/EOP Attached ☐ **COB –** Related Adjustment Primary Insurance	☐ **Payment Amount:** _____ ☐ **Claims Reversal Needed** Reason: _____ ☐ **Under/Overpayment –** Explain the reasoning: _____
☐ **Retrospective Medical Review:** Attach reason Prior Authorization was not obtained for service performed and attach medical records.	☐ **Service is not a duplicate -** Explain the reasoning: _____
Comments/Other:_____ _____ _____	