PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Provider Appeal Form

☐ Medicaid ☐ Marketplace

All fields must be completed to successfully process your request.
Provider appeals and provider claim appeals received with a missing or incomplete form will not be processed and returned to sender. Please attach all pertinent documentation to this form.

Submission Methods:

- Fax: 1-866-315-2572
- Online Portal: www.Availity.com
- Email: MHK_Provider_GnA@molinahealthcare.com
- Mail: Passport Health Plan of Molina Healthcare
  Attention: Provider Appeals
  PO BOX 7114
  London, KY 40742

Claims Denied for Missing Documentation:
Claims denied for missing or additional documentation requirements such as consent forms, invoices, explanation of benefits from other carriers, or itemized bills are not considered claim appeals. In order to process your claim appropriately and promptly, these documents, along with a claim, must be received within timely filing requirements. Do not include a provider appeal form with your request.

Please mail to:
KY Claims Corporate PO BOX
Passport Health Plan of Molina Healthcare
PO BOX 7114
London, KY 40742

Provider Information	
Provider/Group Name:	NPI:
Contact Person:	Contact Phone #:
Member Information	
Member Name:	Member ID:
Claim Information/Authorization Information	
Claim ID:	
Billed Amount:	
Date of Service:	
Authorization ID (If Applicable):	
Appeal Reason	
☐Untimely claim filing (Proof of timely filing must be included)	
☐Coding	☐Payment Dispute
☐Authorization	☐Other/Comments: