Provider Early Reversal Permission Form-
Self Disclsoure

Provider is requesting Molina Healthcare of New York, Inc. / Senior Whole Health of New York, Inc. (collectily Molina Healthcare) to accept payment and/ or deduct the claim(s) paid in error from a future Remittance.

Provider Name _____ Provider Tax Id Number _____

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

Molina Claim Number	Overpayment Amount	Overpayment Reason

Comments _____

_____

_____

_____

Fax Submission (Future Claim Deduction)

Fax Number: 844-305-2186
Subject Line: *Provider Overpayment Self Disclosure – [Provider Name]*

Mail Submission (Form and Check)

Mailing Address:
Molina Healthcare
Claims Recovery Department
P.O. Box 744627
Atlanta, GA 30374-4627

Completed by (MHI staff) _____ **Date Reversals Completed** _____