

Claims Dispute Request Form



This form is for all providers disputing a claim with Molina Healthcare of Illinois and serving members in the state of Illinois.

Requests must be received within 90 days of date of original remittance advice. Please allow 30 days to process this reconsideration request. Please submit this completed form and any supporting documentation to Molina Healthcare of Illinois.

Availability Portal: Providers are **strongly encouraged** to use Molina's Provider Portal to submit claim disputes: availability.com/molinahealthcare

Fax: The Claims Dispute Request Form can be faxed to Molina at (855) 502-4962. The fax **must** include the Claims Dispute Request Form.

Note: Molina **does not** accept mail/paper Claims Dispute Requests.

Note: Please refer to the corrected claims form for submission guidelines on claims being corrected and not disputed.

☐ Medicaid

☐ MLTSS

☐ Marketplace

☐ MMP (Dual Options)

Number of faxed pages,
including cover sheet: _____

☐ Participating ☐ Not Participating

If not participating with MMP (Dual Options), please include the Waiver of Liability form with your dispute.

Section 1: General Information

Claim Number: (one claim per form)		Member ID:	
Member Name:		Date of Service:	
Provider Name:		Billed Charges (\$):	Contact Person:
Provider ID (TIN):	NPI:	Provider Phone:	Provider Fax (Required*):

☐ *By checking this box, I acknowledge that the fax number provided is HIPAA compliant and can receive the dispute resolution outcome.

Section 2: Type of Claim Dispute Adjustment

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 all supporting documentation.	
<input type="checkbox"/> Member: Processed under incorrect member	<input type="checkbox"/> Provider: Processed under incorrect provider/tax ID number
<input type="checkbox"/> Coding/Bundling Edits: Attach supporting documentation/ medical records (Documentation is required)	<input type="checkbox"/> Timely Filing: Attach claims & supporting documentation showing claim was filed to Molina in a timely manner
<input type="checkbox"/> Coordination of Benefits Information: Alternate Insurance Information /EOP Attached <input type="checkbox"/> COB – Related Adjustment Primary Insurance <input type="checkbox"/> Retrospective Medical Review: Attach reason Prior Authorization was not obtained for service performed and attach medical records.	<input type="checkbox"/> Payment Amount: _____
	<input type="checkbox"/> Claims Reversal Needed Reason: _____
	<input type="checkbox"/> Under/Overpayment – Explain the reasoning:
	<input type="checkbox"/> Service is not a duplicate – Explain the reasoning:
<input type="checkbox"/> Pre-Authorization now on file: _____	
Comments/Other: _____	
For Internal Use Only: Resolution: _____ _____ _____	

CONFIDENTIALITY NOTICE: This communication, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this communication is prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately and destroy the original documents. Thank you.