

Appeals

Appealing a Claim

(Available in most states)

The Appeal Claim module has three (3) functionalities:

- Submitting Provider Appeal Request Form
- Waiver of Liability Form
- Email Confirmation

Submitting Provider Appeal Request Form

To appeal a Claim, choose **Claims Status Inquiry** from the left menu and follow the steps to find and select the Claim you are appealing. After the Claim is selected, the Claim Details Page will appear, select the **Appeal Claim** Button. The Provider Appeal Request Form page comes prepopulated with details from the original claim:

- All populated data cannot be updated, these values are set and cannot be changed.

Waiver of Liability Form

For non-contracted Medicare and MMP Providers only: please complete and attach the **Waiver of Liability** along with your appeal.

- Print, fill out, scan, and save the form to your computer then attach the document to the appeal along with all other supporting documents.

Appeal Attachment Rules

- Attach any supporting documents that are related to the appeal request.
- Maximum file size is 5MB for individual files, and 20MB for the total size of all attachments
- Attachments must be submitted in one of the following formats: .tif, .gif, .pdf, .bmp, or .jpg.
- Attachments can be uploaded by using the Supporting Information section.

Provider Appeal Request Form

Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit.
3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgment will be provided following the submission of your request.

Provider's Name:	MOLINA MEDICAL	NPI:	1111111111	Federal ID:	2222222222
Request Type:	Appeal	Participation Status:	<input checked="" type="radio"/> Contract <input type="radio"/> Non - Contracted		
Claim Number:	10101010101	Date of Service From:	07/26/2015	Total Billed Charges:	226.80
CPT Code:		Authorization Number:	mm000/yyyy		
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH, CA 90802	Email Address:	Molina.Medical@mohiathet.com
Contact Person:		Phone:		Fax Number:	
Member's ID:	3333333333	Member Name:	DOE, JOHN	Date of Birth:	07/07/2007
					mm/dd/yyyy

Specific Issue(s): Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support your request.

Supporting Information

Attachments: Attach copies of any records you wish to submit below

Type of Attachment: File:

Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.

Subscriber Name: Submission Date: 07/13/2017 Receipt Date: 07/13/2017

By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.

- Once all fields have been completed and attachments made, you must agree to the terms and conditions by typing your name into the Submitter Name field.
- The check box next to the disclaimer at the bottom of the form will also need to be selected.
- The appeal request is considered complete once the **Submit** button has been selected at the bottom of the form.

Email Confirmation

Upon submission, you will receive an email to confirm that the online appeal was submitted successfully.