MOLINA HEALTHCARE

Marketplace
PRE-SERVICE APPEAL REQUEST FORM

If you want to appeal the decision we have made, you can write a letter or fill out this form. You have up to 60 calendar days from the date on the Notice of Adverse Benefit Determination (denial letter) for an appeal. You can also call us to appeal within 60 calendar days from the date on the Notice of Adverse Benefit Determination letter. If you call us first for an appeal, you must still send your appeal request in writing to us after you called us.

If you or your doctor thinks your life or health is in immediate danger because of the decision in the Notice of Adverse Benefit Determination letter, you or the doctor acting on your behalf can ask for a quick (expedited) appeal. If you call us to request a quick appeal, you do not need to send a letter or this form to Molina.

If you want help filling out this form, please call Member Services at (866) 472-9484, TTY/TDD: 711.

Who is requesting this appeal (check one)?

☐ Member ☐ Healthcare Provider

Date: _____/_____/_____

Member ID _____

MEMBER INFORMATION

LAST NAME:	FIRST NAME:	MI:
Member Address:		
CITY:	STATE:	ZIP:
Member Phone #:( )		
Member Email:		
Reason for Appeal:		

HEALTHCARE PROVIDER INFORMATION

Doctor Name:		
Doctor Address:		
CITY:	STATE:	ZIP:
Name of Contact at Doctor's Office:		
Doctor Phone #: ( )	Doctor Fax #:	
Reason for Appeal:		

*****Please attach any medical information that will help us to understand your medical condition and your appeal, and send it to:**

Molina Healthcare of Mississippi
Attn: Member Grievance and Appeals
188 E. Capitol Street, Suite 700
Jackson, MS 39201
Fax Number: (844) 808-2407