Claim Reconsideration Request Form

Date: __/__/____

- Please submit the request by visiting our **Provider Portal**, or fax to **(800) 499-3406**.
- Attach all required supporting documentation.
- Incomplete forms will not be processed. Forms will be returned to the submitter.
- Please refer to the Molina Provider Manual for timeframes and more information.
- Appeals related to Authorizations should be submitted using the **Authorization Reconsideration Form**.

Corrected Claims
Please send corrected claims as a normal claim submission electronically or via the **Provider Portal**.

Multiple Claims
If multiple claims with the same denial require an appeal, attach an Excel sheet.
Note: Multiple claims must be from the same rendering provider and for same claim denial reason.

Provider Information			
Contact Person		**Contact Phone #**	
Provider/Group Name			
Provider NPI		**Provider Tax ID/Medicare ID**	
Provider Phone #		**Provider Fax #**	

Member Information			
Member Name		**Member Account #**	
Member Date of Birth		**Molina Member ID**	

Claim Information					
Line of Business	☐ Medicaid	☐ Marketplace	☐ Medicare	☐ MMP	☐ LTSS
Claim Information	☐ Single Claim		☐ Multiple Claims		
Molina Original Claim ID					
Original Claim Amount Billed					
Dates of Service					

Denial Reason (Mark all applicable)	
☐ **Duplicate Service**	☐ **Coordination of Benefits (COB)**
☐ **Processed under incorrect Provider/Tax ID**	☐ **Processed under incorrect member**
☐ **Overpayment/Underpayment**	☐ **National Correct Coding Initiative (NCCI) Edit**
☐ **Exceeded timely filing limit**	☐ **Eligibility**
☐ **Missing/Incorrect NDC**	☐ **Other (Please explain)**

Additional Information: