MEDICAL APPEAL REQUEST

If you want to appeal our decision, you can write a letter or fill out this form and send it to us within 60 calendar days from the date on the Notice of Adverse Benefit Determination for a regular appeal. You can also call us within 60 calendar days from the date on the Notice of Adverse Benefit Determination.

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 an expedited (quick) appeal by calling us. If you call us to request a quick appeal, you do not need to send Molina this form.

If you want help filling out this form, please call (855) 882-3901.

Who is requesting this appeal (check one)?

☐ Member ☐ Healthcare Provider Date: _____

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 South Carolina
C/O Firstsource
PO Box 182273
Chattanooga, TN 37422 or
Fax Number: (877) 823-5961