MEDICAL APPEAL REQUEST

If you want to appeal the decision we have made, 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 call us first, you must still send a letter or this form to us within 30 calendar days 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 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 Appeals Department
Attn: MIRR Department
P.O. Box 40309
North Charleston, SC 29423-0309
Fax Number: (877) 823-5961