MOLINA HEALTHCARE | Molina Complete Care

APPEAL REQUEST FORM

If you don't agree with the decision Molina Complete Care (MCC) has made on a service request or payment issue, you have the right to appeal. You may also file an appeal with the Department of Medical Assistance Services (DMAS) Appeals Division, but you must file an appeal with MCC first. You have 60 calendar days from the date on the service letter or payment decision to appeal. After 60 calendar days, it is too late to appeal the decision. If you ask for an appeal by calling us, you must also send your request to us in writing within 10 days. Below is a form to assist you in making your appeal request in writing. You can provide it to us in person or in writing to:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030
or
Fax: 1-866-325-9157

If you are in need of assistance completing this form please call Member Services from 8 a.m. to 8 p.m. local time, Monday through Friday.

- Commonwealth Coordinated Care Plus: 1-800-424-4524 (TTY 711)
- Medallion 4.0: 1-800-424-4518 (TTY 711)

Member Name:	**Claim Number:**
Member ID:	**Member Date of Birth:**
Date of Service:	**Provider:**
Preferred Contact Phone Number:	
Preferred Address:	
Service(s) appealed:	
Are you requesting Continuation of Benefit? ☐ Yes ☐ No Please note that if the original adverse decision is upheld you may be responsible for paying for the care received during the appeal process**.** The Continuation of Benefit request must be received by MCC within 10 calendar days of the initial denial/reduction or within 10 calendar days of service end date.	
Reason for appeal: _____ _____	

Please send any additional information you would like us to consider in deciding your appeal.