



## Provider Dispute/Appeal Form

Please submit your request by visiting our Provider Portal at <https://provider.molinahealthcare.com>

All fields must be completed to successfully process your request.

Disputes/appeals received with a missing or incomplete form will not be processed and returned to sender. Please attach all pertinent documentation to this form.

### Additional submission methods:

- Fax: (877) 553-6504
- E-mail: [MFL\\_ProviderAppeals@Molinahealthcare.com](mailto:MFL_ProviderAppeals@Molinahealthcare.com)
- Mail: Molina Healthcare of Florida 8300 NW 33rd street Doral, FL 33122

### Claims Denied for Missing Documentation

Claims denied for missing or additional documentation requirements such as consent forms, invoices, Explanation of Benefits from primary carrier, or itemized bills are not considered claim disputes. In order to process your claim appropriately and promptly, these documents, along with a copy of the claim, must be received within federal and state timely filing requirements and/or your Provider Services Agreement. Please mail the documentation with the copy of the claim to:

**Molina Healthcare of FL  
P.O. BOX 22812  
Long Beach, CA 90801**

### **Provider Information**

Provider/Group Name:

NPI:

Contact Person:

Contact Phone #

### **Member Information**

Member Name:

Member ID:

Member DOB:

### **Claim Information**

Line of Business:  MMA (Medicaid)  Marketplace  Medicare

Molina Original Claim ID:

Original Claim Billed Amount:

Date of Service:

### **Denial Reason**

Untimely claim filing (Proof of timely filing must be included)

Benefit Limitation Exceeded\*

Underpayment/Overpayment

Authorization Issue/Medically Necessary\*

Other

Comments:

\*Medical Records are required

Provider Dispute/Appeal Form 1-1-2020