

### Welcome to the Provider Portal!

Take care of business on your schedule. The portal is yours to use 24 hours a day, seven days a week. It's an easy way for you to accomplish a number of tasks, including:





Once the provider has successfully logged in, they will be to routed to the Provider Portal home page.

			00000	1000 - Other Lines Of Business - XXX0000 - MOL	INA MEDICAL CENT	ER - WEST
MOLINA Pr HEALTHCARE Pr	ovider Self Services			Welcome, Home Provider Sear	-	2015 7:02:48 AM
Provider Portal	Messages and Announcer	nents	Recent Activity		My Favor	rites
Member Eligibility	You have (0) new messages		Click here to view you	ur recent Service Request/Authorizations		
<ul> <li>Claims</li> </ul>	lou have (4) announcements		Click here to view you	ur recent Claims	Member Eligibility	Create
<ul> <li>Service Request/Authorization</li> </ul>						Professional Claims
Member Roster	Q	uick Membe	er Eligibility Sear	ch	R.e.	
HEDIS Profile	Sea	rch by Member ID		Go		
Reports					Create Institutional Claim	Claim Status Inquiry
Links	What's New	Coming S	oon !	Poll		
Forms	June 2015 <ul> <li>HEDIS Profile now available for SC and</li> </ul>		!! allowing ICD-10 codes on	Do you like our new look?		SRA
Account Tools	<ul> <li>HEDIS Profile now available for SC and IL</li> </ul>		uests beginning 8/5/2015. ou ready? Take our Provider	Ves	Downloaded Claims Report	Create Service Reguest/Autho
			y. Interested in testing?	Vote See Responses		
	• 0		• • •		Service Request/Authoriz atio.	Member Roster



By selecting the Claims Status Inquiry feature, the provider may search for the claim that they would like to appeal.





### **Claims Inquiry**

Search Billing Provider: Select   Claim Type: All   Claim Status  Additional Search Filters Enter optional criteria to narrow your search		Search for claim using available search filters
Received Date: From: IF To:	mm/dd/yyyy mm/dd/	To: III III III
Rendering Provider: Select Coverage Type: All	▼ Gender: ▼ Claims Status: All ▼	Patient Control No:
		Search Clear Cancel

The provider may search for the desired claim using any of the available search filters (claim status, claim number, dates of service, etc.)



### **Claims Found**

Claim ID 🕜	Member Name 🔞	Billed	Service Date From	Service Date	Received Date	Submission Type*	<u>Status</u>	<u>Status</u> Date	<u>Claim</u> Type	Attachments
	Select cla	im				Select *	Select V		Select •	
0101010101	ID for desir	ed	03/21/2017	03/21/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
11112222333	claim	.00	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
9876543210		24	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
0123456789	SMITH. JOHN	2,167.00	09/14/2016	09/14/2016	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
111111111	DOE, JANE	8,161.00	10/15/2016	10/15/2016	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
2222222222	SMITH. JOHN	3,363.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
3333333333	SMITH. JOHN	3,447.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
444444444	DOE, JANE	5,235.00	03/20/2017	03/20/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
555555555	DOE, JANE	3,420.00	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	
777777777	SMITH, JOHN	5,832.24	03/22/2017	03/22/2017	03/28/2017		Pending/In Process	03/28/2017	INSTITUTIONAL	

Print

\*Submission Types are only applicable to claims submitted via Web Portal.

Once the search results display, the provider will need to click on the desired claim ID to access the claim details.



### **Claim Details**

General Ir	nformation												
	Member N	ame: EVERDEE	N, KATNISS				Claim	Number:101	0101010				
С	laim Status Cate	gory:				(	Claim Status I	Effective: 8/31	1/2015				
	Claim Header St	atus: Denied					Billed Ar	mount(\$): 68.0	00				
Rend	ering Provider N	ame: MOLINA I	MEDICAL				Check	Number:					
Re	ndering Provider	NPI: 11111111	1				Service Da	ate From: 8/31	1/2015				
	Check Paid I	Date: 03/14/201	6			P	atient Control	Number: 222	222222				
	Service Dat	e To: 8/31/2015					Amoun	t Paid(\$): 0.00	)				
Claim Lin	e Items												
Claim Line	Service From Date	Service To Date	Rev Code	Service Code	Modifiers	Units	Billed Amt	Seleo	ct "Appeal	Claim"	ine Status Effective	Status	Remit Message
1	08/31/2015	08/31/2015		99232		1	68.00		button		8/31/2015	No Payment will be made for this claim line	Claim denied charges.
	Sho	owing 1-1 of 1	10	<ul> <li>per page</li> </ul>	je							l∎ ∎ Pag	je 1 of 1 ► ►I
				Save As T	emplate	Appeal C	laim V	oid Claim	Correct Claim	View Diagnos	is Code	Print Claim Summary	Back

- Once routed to the Claim Details page, the provider can access the Provider Appeal Request Form by selecting the "Appeal Claim" button.
- Note: The "Appeal Claim" button will only be available for finalized (paid, denied, etc.) claims.



The Provider Appeal Request Form will then display with the following information auto populated:

- 1. Provider Name
- 2. NPI
- 3. Federal ID
- 4. Claim Number
- 5. Date of Service
- 6. Total Billed Charges
- 7. Address
- 8. City/State/Zip
- 9. Member ID
- **10.** Member Name
- 11. Date of Birth
- 12. Submission Date
- **13. Receipt Date**

#### **Provider Appeal Request Form**

#### Instructions for filing an Appeal:

- 1. Fill out this form completely. Describe the issue(s) in as much detail as possible
- 2. Attach copies of any records you wish to submit.
- 3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name: *	MOLINA MEDI	CAL	NPI:*	111111111		Federal ID:*	222222222	
Request Type:	Appeal		Participation Status:	Contract ON	on - Contra	acted		
Claim Number:*	10101010101		Date of Service From:*	07/26/2015 mm/dd/yyyy	Ê	Total Billed Charges:	226.80	
CPT Code:			Authorization Number:					
Address:	777 MOLINA V	VAY	City/State/Zip:	LONG BEACH,CA	,90802	Email Address:	Molina.Medical@m	olinahea
Contact Person: *			Phone:*			Fax Number:		
Member's ID:*	3333333333		Member Name:*	DOE, JOHN		Date of Birth: *	07/07/2007 mm/dd/yyyy	
Specific Issue(s):	Please state all	details relating to yo	ur request including name	s, dates and places	. Attach a	Il supporting materials below to su	ipport your request.	
				1				
Supporting In								
Attachments: Attach co	pies of any recor	ds you wish to submit I	below					
Type of Attachmer	nt : Select				•			
Fi	e : Choose F	ile No file chosen				Upload		
						l. Upload 1 file at a time. ts should not exceed 20 MB.		
Submitter Name:*			Submission Date:	07/13/2017		Receipt Date:	07/13/2017	
	Appeals submit been selected.	tted after 5pm are co	onsidered to be received	on the following b	usiness da	y. The receipt date will be captu	red once the submit	button has
						ly authorized to act on behalf of s truthful and correct to the best		ider
Print	Submit	Cancel	,				,	



- All populated data can be updated by backspacing and typing the correct info into the field.
- All fields with the exception of Member ID, Member Name, DOB, and Email Address are editable.
- The Submission Date & Receipt Date are populated based on the time zone of the logged in provider. These values are set and cannot be changed.

#### **Provider Appeal Request Form**

#### Instructions for filing an Appeal:

Print

Submit

Cancel

1. Fill out this form completely. Describe the issue(s) in as much detail as possible

2. Attach copies of any records you wish to submit.

The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	11111111	Federal ID:*	22222222
Request Type:	Appeal	Participation Status:	Contract      Non - Contra	acted	
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	333333333	Member Name:*	DOE, JOHN	Date of Birth: "	07/07/2007 mm/dd/yyyy
Type of Attachme	ppies of any records you wish t nt : Select ile : Choose File No file cl Upload files only whe				
	been selected. ne below, I certify that I am	Submission Date: m are considered to be received either the submitting healthcarr all information in any form subm	e provider or that I am legal	ly authorized to act on behalf of	the healthcare provider



- The provider may attach any supporting documents that are related to the appeal request.
- Maximum file size is
   5MB for individual files, and 20MB for the total size of all attachments.
- Attachments must be submitted in one of the following formats: .tif, .gif, .pdf, .bmp, or .jpg.
- Attachments can be uploaded by using the Supporting Information section.

#### **Provider Appeal Request Form**

#### Instructions for filing an Appeal:

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2. Attach copies of any records you wish to submit.

3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	11111111	Federal ID:*	22222222
Request Type:	Appeal	Participation Status:	Contract      Non - Contract	acted	
Claim Number:*	10101010101	Date of Service From:	07/26/2015	Total Billed Charges:	226.80
CPT Code:		Authorization Number			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	333333333	At	tach	Date of Birth: *	07/07/2007 mm/dd/yyyy
Specific Issue(s):	Please state all details rel	supp	oorting Jments	supporting materials below to se	upport your request.
	opies of any records you wish	n to submit below			
Type of Attachme	nt: Select ile: Choose File No file		•	Upload	
		hen you want to add supporting do Jloaded file should not exceed 5MB			
Submitter Name:*		Submission Date:	07/13/2017	Receipt Date:	07/13/2017
	Appeals submitted after : been selected.	5pm are considered to be received	on the following business d	ay. The receipt date will be captu	ired once the submit button h
	ne below, I certify that I a	am either the submitting healthcar ad all information in any form subm			
Print	Submit Can				, meneager



Once all fields have been completed and attachments made, the provider will need to agree to the terms and conditions by typing their name into the *Submitter Name* field.

#### Provider Appeal Request Form

#### Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible

2. Attach copies of any records you wish to submit.

 The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Provider's Name:*	MOLINA MEDICAL	NPI:*	11111111	Federal ID:*	22222222
Request Type:	Appeal	Participation Status:	Contract      Non - Contract	tracted	
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID: *	333333333	Member Name:*	DOE, JOHN	Date of Birth: *	07/07/2007
Supporting Ir Attachments: Attach co Type of Attachme	opies of any records you wish t	o submit below			
	ile : Choose File No file ch	nosen		Upload	
	Upload files only whe Max size of each uplo		le	eal. Upload 1 file at a time. nts should not exceed 20 MB.	
	4	nar	ne		
Submitter Name:*		Submission Date:	07/13/2017	Receipt Date:	07/13/2017
	Appeals submitted after 5p been selected.	m are considered to be received	on the following business o	day. The receipt date will be captu	red once the submit button has

By entering my name below, I certify that I am either the submitting healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.

Print Submit Cancel



**Provider Appeal Request Form** 

2. Attach copies of any records you wish to submit.

a submission of concernant

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.

Instructions for filing an Appeal:

The check box next to the disclaimer at the bottom of the form will also need to be selected.

Provider's Name: *	MOLINA MEDICAL	NPI:*	11111111	Federal ID:*	22222222
Request Type:	Appeal	Participation Status:	Contract     Non - Contract	ed	
Claim Number:*	10101010101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID: *	333333333	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007
Specific Issue(s):	Please state all details rela	ting to your request including name	s, dates and places. Attach all s	supporting materials below to su	upport your request.
upporting In tachments: Attach co	nformation			upporting materials below to su	upport your request.
Supporting II ttachments: Attach co Type of Attachme	nformation	to submit below	s, dates and places. Attach all s	upporting materials below to su	upport your request.
<b>upporting II</b> tachments: Attach co Type of Attachme	nformation opies of any records you wish nt : Select ile : Choose File No file c Upload files only why	to submit below hosen en you want to add supporting do oaded file should not exceed 5MB.	▼ cuments to the claim appeal.	<u>Upload</u> Upload 1 file at a time.	upport your request.

3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided

By entering my name occur, a control of the healthcare provider or that I am legally authorized to act on behalf of the healthcare provider submitting this information. I certify that any and all information in any form submitted to Molina Healthcare is truthful and correct to the best of my knowledge.

Print Submit Cancel



The Provider Appeal request is considered complete once the "Submit" button has been selected at the bottom of the form

#### Provider Appeal Request Form

#### Instructions for filing an Appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.

2. Attach copies of any records you wish to submit.

3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided following the submission of your request.

Request Type:       Appeal       Participation Status:       © Contract © Non - Contracted         Claim Number:       10101010101       Date of Service From: $0^{7/26/2015}$ mm/dd//yyy       Total Billed Charges:       22         CPT Code:       Authorization       mm/dd//yyy       Imm/dd//yyy       Total Billed Charges:       23         Address:       777 MOLINA WAY       City/State/2p:       LONG BEACH, CA, 90802       Email Address:       Mm         Contact Person:       Phone:       Fax Number:       Imm/dd//yyy       Date of Birth: $0^7$ Specific Issue(s):       Please state all details relating to your request including names, dates and places. Attach all supporting materials below to supporting the supporting materials below to supporting the supporting materials below to support Field       Upload         Supporting Information       Immediation of the supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.         Submitter Name:       Click "Submit"       D17       Receipt Date:       07         Submitter Name:       Click "Submit"       D17       Receipt Date:       07         Submitter Name:       Click "Submit"       D17       Receipt Date:       07         Submitter Name:       Click "Submit"       D17       Rec						
Claim Number: 101010101 Date of Service From: 07/26/2015 mm/dd/yyyy CPT Code:	Provider's Name: *	MOLINA MEDICAL	NPI:*	11111111	Federal ID:*	22222222
Claim Humble: 10101010101 Charle of derive Prom	Request Type:	Appeal	Participation Status:	Contract      Non - Cont	racted	
CPP Code.       Number:         Address:       777 MOLINA WAY         Contact Person:       Email Address:         Member's ID:       333333333         Member Name:       DOE, JOHN         Date of Birth:       07         Specific Issue(s):       Please state all details relating to your request including names, dates and places. Attach all supporting materials below to support         Supporting Information         Attachments:       Attach copies of any records you wish to submit below         Type of Attachment :       Select         File :       Choce File         No file chosen       Upload         Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.         Submitter Name:       Click "Submit"         Appeals submit       DIZ         Receipt Date:       07         pring business day. The receipt date will be captured or that I an legally authorized to act on behalf of the	Claim Number:*	10101010101	Date of Service From:*		Total Billed Charges:	226.80
Contact Person: Phone:	CPT Code:					
Member's ID:       333333333       Member Name:       DOE, JOHN       Date of Birth:       07         Specific Issue(s):       Please state all details relating to your request including names, dates and places. Attach all supporting materials below to supporting <b>Comporting Information</b> Supporting Information         Attachments:       Attach copies of any records you wish to submit below       Image: Compose File       Image:	Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Specific Issue(5):       Please state all details relating to your request including names, dates and places. Attach all supporting materials below to suppo         Supporting Information         Attachments: Attach copies of any records you wish to submit below         Type of Attachment :       Select         File :       Choose File No file chosen         Upload         Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.         Submitter Name:       Appeals subm <sup>2</sup> Appeals subm <sup>2</sup> Image: Click "Submit"         By entering my name below       rot that I am legally authorized to act on behalf of the	Contact Person:*		Phone:*		Fax Number:	
Supporting Information         Attachments: Attach copies of any records you wish to submit below         Type of Attachment :       Select         File :       Choose File         No file chosen       Upload         Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time.         Max size of each uploaded file should not exceed SMB. Total Size of all Attachments should not exceed 20 MB.         Submitter Name:           Appeals subm <sup>2</sup> By entering my name belov               roth the receipt date will be captured	Member's ID:*	333333333	Member Name:*	DOE, JOHN	Date of Birth: *	07/07/2007 mm/dd/yyyy
Attachments: Attach copies of any records you wish to submit below          Type of Attachment :       Select         File :       Choose File       No file chosen       Upload         Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed SMB. Total Size of all Attachments should not exceed 20 MB.       Image: Click "Submit"       Image: Dispeals submit below         Submitter Name:       Appeals submit below       Image: Dispeals submit below	Specific Issue(s):	Please state all details relat	ting to your request including name	s, dates and places. Attach	all supporting materials below to su	upport your request.
Attachments: Attach copies of any records you wish to submit below          Type of Attachment :       Select         File :       Choose File       No file chosen       Upload         Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed SMB. Total Size of all Attachments should not exceed 20 MB.       Image: Click "Submit"       Image: Dispeals submit below         Submitter Name:       Appeals submit below       Image: Dispeals submit below	Cupporting Is	formation		1		
Type of Attachment : Select File : Choose File No file chosen Upload Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed SMB. Total Size of all Attachments should not exceed 20 MB. Submitter Name: Appeals subm <sup>2</sup> By entering my name belov Toty the Click "Submit" D17 Receipt Date: 07 owing business day. The receipt date will be captured or that I am legally authorized to act on behalf of the						
File : Choose File No file chosen Upload Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed SMB. Total Size of all Attachments should not exceed 20 MB. Submitter Name: Appeals subm <sup>2</sup> By entering my name belov unity the Click "Submit" By entering my name belov unity the Click and the content of the captured or or that I am legally authorized to act on behalf of the	Attachments: Attach co	opies of any records you wish t	to submit below			
Upload files only when you want to add supporting documents to the claim appeal. Upload 1 file at a time. Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.         Submitter Name:       Click "Submit"         Appeals subm <sup>2</sup> D17         By entering my name belov       entry the	Type of Attachme	nt : Select		Ŧ		
Max size of each uploaded file should not exceed 5MB. Total Size of all Attachments should not exceed 20 MB.          Submitter Name:       Click "Submit"         Appeals subm <sup>2</sup> D17         By entering my name belor       extering the captured of the state of t	Fi	ile: Choose File No file c	hosen		Upload	
Appeals subm <sup>*</sup> been select <sup>*</sup> By entering my name belo <sup>*</sup> and the select of the selec						
been select By entering my name below routing the select on behalf of the	Submitter Name:*		Click "Submit		Receipt Date:	07/13/2017
By entering my name below authorized to act on behalf of the		Appeals subm?		owing business d	ay. The receipt date will be captu	ired once the submit button ha
Print Submit Cancel	) By entering my nar Ibmitting this inform	ne belovertify the ation accertify that any and	all information in any form subm	r or that I am lega netted to Molina Healthcare	ally authorized to act on behalf of is truthful and correct to the bes	the healthcare provider t of my knowledge.*



# **Waiver of Liability Form**

The following verbiage will display in the Supporting Information section when a Medicare or MMP provider selects non contracted as the participation status:

For non contracted Medicare and MMP providers: please complete and attach the <u>Waiver of Liability</u> along with your appeal.

#### Provider Appeal Request Form

#### Instructions for filing an Appeal:

- 1. Fill out this form completely. Describe the issue(s) in as much detail as possible
- 2. Attach copies of any records you wish to submit.
- 3. The completed form will be submitted to the Molina Healthcare Provider Appeals & Grievances department. An electronic acknowledgement will be provided
- following the submission of your request

F	Select	NPI:*	11111111	Federal ID:*	22222222
part	icipation	Participation Status:	Ocontract  Non - Contract	tracted	
5	status	Date of Service From:	07/26/2015	Total Billed Charges:	226.80
or roude.		Authorization Number:			
Address:	777 MOLINA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person:*		Phone:*		Fax Number:	
Member's ID:*	333333333	Member Name: *	DOE, JOHN	Date of Birth:*	07/07/2007 mm/dd/yyyy
Supporting In Attachments: Attach co	pies of any records you wish to	o submit below	T		
	le : Choose File No file ch	iosen		Upload	
	Max size of each uplo	n you want to add supporting do aded file should not exceed SMB I Medicare and MMP provider	. Total Size of all Attachme		vith your appeal.
Submitter Name: *	Appeals submitted after 5p been selected.	Submission Date: m are considered to be received	07/13/2017 on the following business of	Receipt Date: day. The receipt date will be captu	07/13/2017 Ired once the submit button h
				ally authorized to act on behalf of is truthful and correct to the bes	

Print Submit Cancel



## Waiver of Liability Form

### Selection of the *Waiver of Liability* link will route the provider to the Waiver of Liability Form.

Provider's Name:* MOLINA ME	EDICAL	NPI:*	111111111	Federal ID:*	22222222
Request Type: Appeal		Participation Status:	<ul> <li>Contract</li> <li>Non - Contracte</li> </ul>	d	
Claim Number:* 10101010	101	Date of Service From:*	07/26/2015 mm/dd/yyyy	Total Billed Charges:	226.80
CPT Code:		Authorization Number:			
Address: 777 MOLIN	NA WAY	City/State/Zip:	LONG BEACH,CA,90802	Email Address:	Molina.Medical@molinahea
Contact Person: *		Phone:*		Fax Number:	
Member's ID: 133333333	33	Member Name:*	DOE, JOHN	Date of Birth:*	07/07/2007
pecific Issue(s): Please state	te all details relating to your	request including name	s, dates and places. Attach all su		
Ipporting Information	ion ecords you wish to submit bel		s, dates and places. Attach all su	Sel	ect Waiver f Liability link
Ipporting Information achments: Attach copies of any re Type of Attachment : Selec File : Choo Uploa	con ecords you wish to submit bel ct ose File No file chosen ad files only when you wan	iow t to add supporting do		Upload pload 1 file at a tirr	ect Waiver f Liability
Ipporting Information achments: Attach copies of any re Type of Attachment : Selec File : Choo Uploa Max s	ion ecords you wish to submit bel et ose File No file chosen ad files only when you wan size of each uploaded file si	iow t to add supporting do nould not exceed SMB.	T cuments to the claim appeal. U	Upload pload 1 file at a tirr hould not exceed ref.	ect Waiver f Liability link
Ipporting Information achments: Attach copies of any re Type of Attachment : Selec File : Choo Uploa Max s	ion ecords you wish to submit bel et ose File No file chosen ad files only when you wan size of each uploaded file si	iow t to add supporting do nould not exceed SMB.	v cuments to the claim appeal. U Total Size of all Attachments s	Upload pload 1 file at a tirr hould not exceed ref.	ect Waiver f Liability link

Print Submit Cancel

**Provider Appeal Request Form** 

1. Fill out this form completely. Describe the issue(s) in as much detail as possible

Instructions for filing an Appeal:



### **Waiver of Liability Form**

- Once the Waiver of Liability link is selected, the Waiver of Liability Form will display in a new window.
- The provider will need to print, scan, and save the form to their computer in order to attach the document to the appeal along with all other supporting documents.

Appendix 7 - Waiver of Liability Statement (Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

#### WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee's Name

Provider

Dates of Service

Health Plan

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature

Date



### **Email Confirmation**



On [##CURRENTDATE], we received your request appealing the action taken for the following claim(s) 012345678910 . We will review your request and provide a decision when a resolution has been reached.

If you have any additional questions please call the Provider Contact Center.

Sincerely, Provider Inquiry, Research & Resolution Molina Healthcare

Upon submission, providers will receive an email confirmation which will serve as an electronic acknowledgement letter for the provider.

Verbiage in the acknowledgement letter will display differently for California providers.



### **Email Confirmation**

#### You have received a secure message

Read your secure message by opening the attachment, securedoc.html. You will be prompted to open (view) the file or save (downlo in a Web browser. To access from a mobile device, forward this message to <u>mobile@res.cisco.com</u> to receive a mobile login URL.

If you have concerns about the validity of this message, contact the sender directly. **First time users** - will need to register after opening the attachment. For more information, click the following Help link. **Help** - <u>https://res.cisco.com/websafe/help?topic=RegEnvelope</u> **About Cisco Registered Email Service** - <u>https://res.cisco.com/websafe/about</u>



### All email confirmations will be sent in a secure format.

Upon receipt of the message, the provider will be prompted to do a one time registration with their email address to view the message. A password will be required for all messages received thereafter.