June 5, 2018

Provider Memorandum

Update to Provider Claims Appeals and Disputes Submission Process

Providers who wish to appeal or dispute claims with Molina Healthcare of Illinois (Molina) will be required to submit their documentation via electronic means only, effective September 1, 2018. Paper appeal and dispute submissions that are sent through the mail will no longer be accepted after the effective date.

Molina providers may use one of the following options for submission of a claim appeal or dispute:

- **Provider Web Portal**: Providers may submit their appeals and disputes through Molina's provider web portal. Providers may also submit any supporting documentation for appeals and disputes through the portal. The provider web portal can be accessed on the Molina provider home page at www.MolinaHealthcare.com.

- **Fax**: A Claims Dispute Request Form is required when submitting a claim appeal or dispute via fax. The completed Claims Dispute Request Forms along with supporting documentation may be faxed to Molina at: (855) 502-4962.

The Claims Dispute Request Form for fax submissions may be accessed on Molina's website at: http://www.Molinahealthcare.com/providers/il/medicaid/forms/Pages/fuf.aspx

Providers who have questions, concerns or would like additional training, including how to use the Molina Provider Portal, may contact their provider network managers or the Provider Network Management Department at MHILProviderNetworkManagement@MolinaHealthcare.com.

Providers who need help locating their respective provider network manager, please visit Molina's service area page at http://www.Molinahealthcare.com/providers/il/medicaid/contacts/Pages/servicearea.aspx.

Definitions

Dispute: A formal request for review and reconsideration of a previously adjudicated claim that was either denied (in part or in whole), or the provider feels was underpaid. A dispute must be formally requested within the contractually required timeframe in order to be considered for review and potential reprocessing. Disputes submitted outside of the contractually required timeframe will not be considered for review and reprocessing. Examples include: code edit disputes, eligibility/COB disputes, timely filing disputes, provider billing errors, contract issues, and pay to errors.

Appeal: A formal request to review and reconsider an adjudicated claim that was denied (in part or in whole) and requires medical necessity or outside review. An appeal, must be formally requested using one of the submission processes outlined in this memo. Examples include: no authorization on file, extenuating circumstance cases, initial clinical denial on file, authorization on file does not match claim.