Claims Reconsideration Request Form

This form is for providers contracted with Molina Healthcare of Illinois and serving members in the state of **Illinois**.

Requests must be received within 90 days of date of original remittance advice. Please allow 60 days to process this reconsideration request. Please return this completed form and any supporting documentation to Molina Healthcare of Illinois.

By Mail:
Molina Healthcare of Illinois
Attn: Provider Claim Disputes
1520 Kensington Rd, Suite 212
Oak Brook, IL 60523

By Fax: (855) 502-4962

Providers, please note: See Corrected Claim Form for corrected claim instructions and submission process.

Number of faxed pages (including cover sheet) _____

Section 1: General Information

Claim Number (one claim per form)		Member ID#	
Member Name		Date of Service	
Provider Name		Billed Charges ($)	Contact Person
Provider ID (TIN)	NPI	Provider Phone #	Provider Fax #

Section 2: Type of Claim Adjustment

Based upon the following reason(s), we are requesting reconsideration of this claim.

Type of Claim Reconsideration/Appeal Provider: Please check applicable reason(s) and attach all supporting documentation.	
☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider/tax ID number
☐ **Coding/Bundling Edits:** Attach supporting documentation/ medical records (Documentation is required)	☐ **Timely Filing:** Attach claims & supporting documentation showing claim was filed to Molina in at timely manner
Coordination of Benefits Information: ☐ Alternate Insurance Information /EOP Attached ☐ COB – Related Adjustment Primary Insurance Carrier Information	☐ **Payment Amount:** _____ ☐ **Claims Reversal Needed** Reason: _____ ☐ **Under/Overpayment –** Explain the reasoning: ☐ **Service is not a duplicate –** Explain the reasoning: ☐ **Pre-Authorization now on file –** # _____
Comments/Other:	
For Internal Use Only: Resolution: _____ _____	