

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.	
<input type="checkbox"/> Member: Processed under incorrect member	<input type="checkbox"/> Provider: Processed under incorrect provider/tax ID number
<input type="checkbox"/> Coding/Bundling Edits: Attach supporting documentation/ medical records (Documentation is required)	<input type="checkbox"/> Timely Filing: Attach claims & supporting documentation showing claim was filed to Molina in at timely manner
Coordination of Benefits Information: <input type="checkbox"/> Alternate Insurance Information /EOP Attached <input type="checkbox"/> COB - Related Adjustment Primary Insurance Carrier Information	<input type="checkbox"/> Payment Amount: _____
	<input type="checkbox"/> Claims Reversal Needed Reason: _____
	<input type="checkbox"/> Under/Overpayment - Explain the reasoning:
	<input type="checkbox"/> Service is not a duplicate - Explain the reasoning:
<input type="checkbox"/> Pre-Authorization now on file - # _____	
Comments/Other:	
For Internal Use Only: Resolution: _____	

CONFIDENTIALITY NOTICE: This communication, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this communication is prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.