Provider Early Reversal Permission Form

Senior Whole Health
BY MOLINA HEALTHCARE

Provider is requesting Senior Whole Health deduct the claim(s) paid in error from a future Remittance

Provider Name _____ Provider Tax Id Number _____

Person Requesting Claim(s) Reversal _____ Signature / Date _____

Claim Number	Overpayment Amount	Overpayment Reason

Comments _____

Please fax to: Senior Whole Health Claims Recovery Department @ 781.451.3259

Completed by (MHI staff) _____ **Date Reversals Completed** _____