Claim Denials and Rejections Billing Tips

Rejected vs Denied Claim

Molina processes claims in an accurate and timely manner with minimal disturbances. Claim denials and rejections happen for a variety of reasons.

Rejected Claim – A claim that does not meet basic claims processing requirements.

A few examples of rejected claims include:

- The use of an incorrect claim form
- Required fields are left blank on the claim form
- Required information is printed outside the appropriate fields

Denied claim – The claim has been reviewed and was determined that it did not meet payment requirements.

A few examples of reasons a claim will deny include:

- An invalid modifier submitted on the claim
- A missing provider address, date of service, or NPI number
- A missing corrected claims indicator or original claim number

Top Billing Errors by Providers:

- Member not found
  - Providers are encouraged to verify the beneficiary's eligibility each visit and prior to submission of each claim. Providers should also periodically review the beneficiary's eligibility information.
- Missing incomplete/invalid payer claim control number
  - Corrected or Void/Replacement claims must include the correct coding to denote if the claim is Replacement or Corrected along with the ICN/DCN (original claim ID). ******(Ex. Submit the applicable code in Box 22 on the CMS 1500. Insert 6 (corrected), insert 7 (replacement) or insert 8 (void) and reference the original claim number.)*****
- Paper Claim Rejections
  - To avoid a delay in receiving claim payment, ensure the information provided on a paper claim submission is readable, legible, and does not contain white out (correction fluid/tape)

- Invalid/missing Member ID
    - Member ID can be submitted with or without leading zeroes. When leading zeroes are added, it must only contain 5 leading zeros

How to Correct These Errors

Providers can submit corrected claims by the following:

Preferred Method – online via Molina's Provider Portal:
https://provider.MolinaHealthcare.com/provider/login

Via a Clearinghouse – Molina's Payer ID number is **77010**

Claims Mailing Address
Molina Healthcare of Mississippi, Inc.
PO Box 22618
Long Beach, CA 90801

All reconsiderations must be received within **ninety (90) days** of the date on the Remittance Advice. Molina will respond to your request, in writing, within **thirty (30) calendar days**. Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Mississippi via the Provider Portal at **provider.molinahealthcare.com**
- Submit requests directly to Molina Healthcare of Mississippi by faxing to **1-844-808-2409**

Claims Submission	Time Frame
Initial Claim	180 Days from the DOS/180 Days from the Date of Discharge
Reconsideration/ Correction/Adjustment	90 Days from the date of denial/EOP
COB	180 Days from the Primary Payer's EOP