Provider Early Reversal Permission Form

Provider is requesting Molina Healthcare 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: Molina Healthcare Claims Recovery Department @ 844-891-2863