CHIP Provider Reconsideration Request Form

Today's Date: ____/____/____

- (*) Attach required documentation or proof to support. Incomplete forms will not be processed and returned to submitter.
- Please refer to your Molina Provider Manual for timeframes and more information.
- Please submit your request by visiting our provider portal **provider.molinahealthcare.com**, or fax to **1-844-808-2409**.
- Multiple claims must be from the same rendering provider and same claim issue.

CORRECTED CLAIMS

Please send corrected claims as a normal claim submission electronically or via the Provider Portal.

MULTIPLE CLAIMS

If multiple claims with the same denial require an appeal, attach an excel sheet.

PROVIDER INFORMATION			
Contact Person Name		Contact Person #	( ) -
Provider Group Name			
Provider Name (First and Last)			
Provider NPI		Provider Tax ID or Medicare ID #	
Provider Phone #	( ) -	Provider Fax #	( ) -

PROVIDER INFORMATION			
Patient Last Name			
Patient Last Name			
Patient Last Name			
Patient Date of Birth	/ /	Molina Member ID	

CLAIM INFORMATION			
Line of Business	☐ CHIP		
Claim Information	☐ Single Claim	☐ *Multiple Claims	
Molina Issued Orignal Claim ID*			
Original Claim Amount Billed			
Service From Date	/ /	Service To Date	/ /

DENIAL REASON (Mark all applicable)	
☐ Service is not a Duplicate	☐ Coordination of Benefits (COB) Related
☐ Processed Under Incorrect Provider/Tax ID	☐ Processed Under Incorrect Member
☐ Payments – Over/ Underpayments	☐ National Correct Coding Initiative (NCCI) Edit*
☐ Timely File Limit*	☐ Eligibility Issue
☐ Authorization*	☐ Missing/ Incorrect NDC
☐ Other (Please explain):	

Additional Information :