

Type of Submission	When to Use It	Important Notes	Next Step, if disagree with the outcome	How to Submit
<p>Corrected Claim</p>	<p>To make an incomplete claim, “complete.” Examples:</p> <ul style="list-style-type: none"> To submit information that is needed to process the claim (i.e., primary payer EOB, Invoice, Consent Form, Itemized Bill, etc. To submit an invoice for a procedure code that cannot be priced without it. To change a data point that was wrong on the initial claim (i.e., DOS, Units, NDC, etc.) 	<ul style="list-style-type: none"> Attachments ARE accepted Timely Filing = 180 calendar days from Date of Service Use frequency code 7 Add the original claim# to the corrected claim. Handwritten or stamped information is not permitted 	<p>Submit Reconsideration</p> <p>Submit Provider Claim Appeal</p> <p>Contact your PR Rep at NEProviderRelations@MolinaHealthcare.com</p>	<p>Availity Essentials https://provider.molinahealthcare.com/ Your regular EDI Clearinghouse <i>*Refer to the “Now accepting EDI Attachments” Provider Notice on the website</i></p>
<p>Reconsideration <i>(in Availity, this is also referred to as a Payment Inquiry)</i></p>	<p>To dispute the processing of a “complete” claim. Examples:</p> <ul style="list-style-type: none"> Claim underpaid the contracted amount Service denied for missing Prior Auth and Prior Auth is on file (and claim is still within the timely filing limit). 	<ul style="list-style-type: none"> Attachments ARE NOT accepted Timely Filing = 90 calendar days from date of the Explanation of Payment or Provider Remittance Advice Can submit multiple requests if they are within the timely filing limit. If a Provider Claim Appeal Form is inadvertently included on a reconsideration request, it will be processed as a provider claim appeal (which is only allowed one time). 	<p>Submit Reconsideration</p> <p>Submit Provider Claim Appeal</p> <p>Contact your PR Rep at NEProviderRelations@MolinaHealthcare.com</p>	<p>Availity Essentials https://provider.molinahealthcare.com/</p> <p>Provider Services (844)782-2678 Mon-Fri, 7am to 6pm, Central Time</p>
<p>Provider Claim Appeal</p>	<p>To dispute the processing of a “complete” claim. Examples:</p> <ul style="list-style-type: none"> Claim initially denied for not being our member but the member received retroactive eligibility so the claim can now be processed. Retro authorization was granted and it’s past the timely filing limit. To dispute a timely filing denial using documentation as proof of timely submission. 	<ul style="list-style-type: none"> Attachments ARE accepted. Timely Filing = 90 calendar days from the date of the Explanation of Payment or Provider Remittance Advice This is recommended after other options have been exhausted. Providers have the right to bypass the reconsideration step and go straight to Provider Claim Appeal. Only one Provider Claim Appeal is allowed. The appeal form is located here Provider Appeal Form 	<p>Contact your Provider Relations Rep or refer to the dispute section within your Molina Agreement.</p> <p><i>Please note that State Fair Hearings are permitted for member claim disputes, not provider claim disputes.</i></p>	<p>Availity Essentials https://provider.molinahealthcare.com/</p> <p>Mail Molina Healthcare of Nebraska Appeals & Grievances Unit PO Box 182273 Chattanooga, TN 37422</p>

NOTE: A Complete Claim is defined as one that includes all required documentation and the information on the claim form is accurate.