



Claims Reconsideration Request Form

Requests must be received within 120 days of date of original remittance advice.

Number of faxed pages (including cover sheet): _____

MyCare Ohio Marketplace **Medicaid** Reconsideration **Medicare** Appeal Participating Non-Participating

Please return this completed form and any supporting documentation via fax to **(800) 499-3406**. Claim reconsiderations submitted without a completed form attached will be returned.

PROVIDERS: Please send corrected claims as normal claim submissions via electronic or paper submission. This includes claims with primary payer information and Explanation of Benefits (EOBs). Any corrected claims received as reconsiderations will be returned.

Section 1: General Information

Claim Number: (One claim per form)		Member ID:	
Member Name:		Date of Service:	
Provider Name:		Billed Charges: \$	Contact Person:
Provider ID (TIN):	NPI:	Provider Phone:	Provider Fax:

Section 2: Type of Claim Adjustment

Based upon the following reason(s), we are requesting reconsideration of this claim.

Type of Claim Reconsideration/Appeal Providers: Please check applicable reason(s) and attach all supporting documentation.	
<input type="checkbox"/> Provider: Processed under incorrect provider.	<input type="checkbox"/> Medical Necessity: Attach reason Prior Authorization was not obtained for service performed and medical records.
<input type="checkbox"/> CCI Edits: Attach supporting documentation / medical records (documentation is required).	<input type="checkbox"/> Timely Filing: Attach claim and supporting documentation showing claim was filed to Molina Healthcare in a timely manner.
Payment Amount: <input type="checkbox"/> Claims reversal needed – Explain reasoning: _____ <input type="checkbox"/> Under / Overpayment – Explain reasoning: _____ <input type="checkbox"/> Service is not a duplicate – Explain reasoning: _____ <input type="checkbox"/> Pre-authorization number now on file – Include number: _____	
Comments/Other: _____ _____ _____	

Molina Healthcare's Response: _____ _____ _____
Date Received: _____ Completed by: _____ Date: _____

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