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.	
☐ **Provider:** Processed under incorrect provider.	☐ **Medical Necessity:** Attach reason Prior Authorization was not obtained for service performed and medical records.
☐ **CCI Edits:** Attach supporting documentation / medical records (documentation is required).	☐ **Timely Filing:** Attach claim and supporting documentation showing claim was filed to Molina Healthcare in a timely manner.

Payment Amount:

☐ Claims reversal needed – Explain reasoning:

_____

☐ Under / Overpayment – Explain reasoning:

_____

☐ Service is not a duplicate – Explain reasoning:

_____

☐ Pre-authorization number now on file – Include number:

_____

Comments/Other: _____

_____

_____

Molina Healthcare's Response: _____

_____

_____

Date Received: _____ Completed by: _____ Date: _____

MHO-0779
46945850H0816