Claims Reconsideration Request Form

(Requests must be received within 120 days of date of original remittance advice)
Please allow 30 days to process this reconsideration request

Number of faxed pages (including cover sheet): _____

☐ Marketplace ☐ **Medicaid** Reconsideration ☐ **Medicare** Appeal ☐ Participating ☐ Non-Participating

Please return this complete form and any supporting documentation to: Fax #: (800) 499-3406 Or mail to:
Molina Healthcare of Ohio, Attn: Provider Services, PO BOX 349020, Columbus, OH 43234-9020

PROVIDERS NOTE: Please send Corrected Claims as normal claim submissions via electronic or paper.

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 Provider: Please check applicable reason(s) and attach all supporting documentation.	
☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider / tax id number
☐ **CCI Edits:** Attach supporting documentation / medical records (Documentation is required)	☐ **Timely Filing:** Attach claim & supporting documentation showing claim was filed to Molina in a timely manner.
Coordination of Benefits Information: ☐ Alternate Insurance Information / EOP Attached ☐ COB-Related Adjustment Primary Insurance Carrier information:	**Payment Amount:** ☐ Claims Reversal Needed- Reason: _____ ☐ Under / Overpayment – Explain the reasoning: _____ ☐ Service is not a duplicate - Explain the reasoning: _____ ☐ Pre-Authorization now on file - # _____
Comments/Other:	

For Internal Use Only:
Resolution: _____
_____
For Medicare Use Only - Letter Sent: (circle one) Yes or No Date Letter was sent: _____
Date Received: _____ Completed by: _____ Date: _____

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