



## 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): \_\_\_\_\_

Medicaid Reconsideration    Medicare Appeal    Participating    Non-Participating

Please return this complete form and any supporting documentation to: Fax #: (614) 781-4464 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.	
<input type="checkbox"/> <b>Member:</b> Processed under incorrect member	<input type="checkbox"/> <b>Provider:</b> Processed under incorrect provider / tax id number
<input type="checkbox"/> <b>CCI Edits:</b> Attach supporting documentation / medical records (Documentation is required)	<input type="checkbox"/> <b>Timely Filing:</b> Attach claim & supporting documentation showing claim was filed to Molina in a timely manner.
<b>Coordination of Benefits Information:</b> <input type="checkbox"/> Alternate Insurance Information / EOP Attached	<b>Payment Amount:</b> <input type="checkbox"/> Claims Reversal Needed- Reason: _____
<input type="checkbox"/> COB-Related Adjustment Primary Insurance Carrier information:	<input type="checkbox"/> Under / Overpayment – Explain the reasoning: _____
	<input type="checkbox"/> Service is not a duplicate - Explain the reasoning: _____
	<input type="checkbox"/> Pre-Authorization now on file - #
<b>Comments/Other:</b>  	

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

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