

## **Provider Early Reversal Permission Form**

Provider is requesting Molina Healthcare to deduct the claim(s) paid in error listed below from a future Remittance State: Provider Tax Id Number Provider Name Person Requesting Claim(s) Reversal Signature / Date **Claim Number Overpayment Amount Overpayment Reason** Comments

Please fax to: Molina Healthcare Claims Recovery Department at (877) 480-1127