Claim Inquiry/Appeal Form

Instructions for filing a Claim Inquiry or Appeal:

1. Fill out this form completely. Please describe the issue in as much detail as possible. Please repeat Page 2 if you are submitting more than 3 claims with the same denial reasons. This form can be used for up to 9 claims that have the same denial reason. If you have 10 or more claims, please email MolinaTXProviderAppealsComplaints@MolinaHealthcare.com for the appropriate form.
2. One form per denial reason should be used
3. Attach copies of any records you wish to submit. Please do not submit the original copies.
4. Submit the completed form through one of the following:
    a. Email: MolinaTXProviderAppealsComplaints@MolinaHealthcare.com
    b. Fax: (877) 319-6852
    c. Mail: Molina Healthcare of Texas
        Attention: Texas Claims
        P.O. Box 165089
        Irving, TX 75016

# of pages (including CAF cover sheet) _____ Date: _____

Provider Name: _____ Tax ID: _____ NPI: _____

Request Type: ☐ Inquiry ☐ Appeal Participation Status: ☐ Contracted ☐ Non-Contracted

Contact Person: _____ Phone Number: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Claim Number: _____

Total Charges	Date(s) of Service	Service Code	Authorization Number (if applicable)
Member ID Number	**Member Name**		**Date of Birth**
Claims Issue:			

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Claim Number: ______________________________

Total Charges	Date(s) of Service	Service Code	Authorization Number (if applicable)
Member ID Number	**Member Name**		**Date of Birth**
Claims Issue:			

Claim Number: ______________________________

Total Charges	Date(s) of Service	Service Code	Authorization Number (if applicable)
Member ID Number	**Member Name**		**Date of Birth**
Claims Issue:			

Claim Number: ______________________________

Total Charges	Date(s) of Service	Service Code	Authorization Number (if applicable)
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