Molina Healthcare of Texas
Provider Complaint/Appeal Request Form

Instructions for filing a complaint/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit. (Do Not Send Originals).
3. You may submit the completed form through one of the following ways:
   a. Send to the address listed below,
   b. Fax to the fax number below, or
   c. Present your information in person. To do this, call us at the number listed below.

   We will send a written acknowledgement letter of your request. It will be mailed to you within three (3) working days after the request is received.

Provider's Name: _____ NPI: _____ Federal ID: _____

Request Type: ☐ Complaint ☐ Appeal **Participation Status:** ☐ Contract ☐ Non-Contracted

Claim Number: _____ DOS: _____ Total Charges: _____

Address: _____ City/State/Zip: _____

Contact Person: _____ Phone: _____

Member's ID #: _____ Member Name: _____ DOB: _____

Specific issue(s): _____

_____

_____

_____

_____

_____

_____

(Please state all details relating to your request including names, dates and places. Attach another sheet of paper to this form if more space is needed)

By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Provider's Signature: _____ Date: _____

Molina Healthcare of Texas
Attn: Provider Complaints & Appeals
P.O. Box 165089
Irving, TX 75016
Or Fax to (877) 319-6852