MOLINA HEALTHCARE

Your Extended Family.

Provider Appeal Form

Today's Date_____

Member Information

Member ID Number:	Member Name:	Member DOB:

Provider Information

Provider Name:	NPI:	TIN:
Office Contact:	Contact Phone Number:	Contact Email Address:
Contact Mailing Address:		

Claim Information

Total claims attached for appeal_____

Molina Claim Number:	Service Date:	Billed Amount:
Molina Claim Number:	Service Date:	Billed Amount:
Molina Claim Number:	Service Date:	Billed Amount:

*If multiple claims with the same denial require an appeal a spreadsheet may be attached with the above information included.

Denial reason: *(mark all that are applicable)*

- ☐ Service/Procedure bundled (attach supporting documentation)
- ☐ Submit primary carrier explanation of benefits (EOB)
- ☐ Prior authorization required
- ☐ Exceeded timely filing (attach proof of timely filing)
- ☐ Other_____

For your appeal to be considered, document below the reason for appeal and include all supporting documentation (e.g. office notes, authorization, practice management print screens)

Reason for appeal: (required - use additional paper if needed)

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Include Molina's EOB along with all supporting documentation and submit directly via:

1. **Email:** MWIAppeals@Molinahealthcare.com *(must be submitted via secure email only – if you don't have secure email capabilities then fax or mail your appeal)*
2. **Fax:** **844-251-1446** *(keep your fax confirmation sheet)*
3. **Mail:** Molina Healthcare of WI, Inc.
   Attn: Appeal Department
   P.O. Box 242480
   Milwaukee, WI 53224-9050