Wisconsin Provider Appeal Form

Line of business: ☐Marketplace ☐Medicaid ☐Medicare

Submission Date: _____

All appeals MUST be submitted via Provider Portal, secure email, or fax. Paper appeals not accepted or processed.

Include Molina's EOB with all supporting documentation. Submit to the appropriate line of business.

For Medicaid and Marketplace

1. Provider Portal: **Provider.MolinaHealthcare.com** (preferred method)
1. Email: **MWIAppeals@MolinaHealthcare.com**
1. Fax: **(844) 251-1446** (keep your fax confirmation sheet)

For Medicare

1. Provider Portal: **Provider.MolinaHealthcare.com** (preferred method)
2. Fax: **(562) 499-0610** (keep your fax confirmation sheet)

Corrected Claims

Send corrected claims as normal claim submissions electronically or via the Provider Portal. This includes claims with primary payer information and EOBs. Any corrected claims received as appeals will not be processed.

Member Information

Member ID Number	Member Name	Member DOB

Provider Information

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

Claim Information

Total number of 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

Multiple claims with the same denial require an appeal. Attach an Excel spreadsheet with a list of claims, and send in Excel format via email to:

For Medicaid and Marketplace
MWIAppeals@MolinaHealthcare.com.

Denial reason (mark all that are applicable)

☐ Service/Procedure bundled (attach supporting documentation)
☐ National Correct Coding Initiative (NCCI) edit
☐ Code changes: enter code here _____
☐ Payments- over/underpayments
☐ 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, you must complete the Reason for Appeal section below. Be sure to include all supporting documentation, including office notes, authorization, and practice management print screens.*

Reason for Appeal

NOTE: Member Appeal

Do not use this form for an appeal submitted on behalf of the member for a denied prior authorization before the service has been performed. Please use the Member Grievance and Appeal form located at MolinaHealthcare.com/providers/wi/marketplace.com and fax the completed form to (844) 251-1445.