MOLINA HEALTHCARE
Your Extended Family.

Provider Appeal Form

Line of business: ☐ Marketplace ☐ Medicaid ☐ Medicare

Today's Date_____

Member Appeal

Do not use this form for an appeal being 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 to (844) 251-1445.

Corrected Claims

Send corrected claims as normal claim submissions electronically or via the Provider Portal. This includes claims with primary payer information and Explanation of Benefits (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 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, attach an excel spreadsheet and send in excel format via email to 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, document below the reason for appeal and include all supporting documentation, including office notes, authorization and practice management print screens.

Reason for appeal:

_____

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Note: Appeals MUST be submitted via fax, secure e-mail or the Provider Portal. Paper appeals will be rejected and not processed.

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

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

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