Claims Dispute Request Form

This form is for all providers disputing a claim with Molina Healthcare of Illinois and serving members in the state of Illinois.

Requests must be received within 90 days of date of original remittance advice. Please allow 60 days to process this reconsideration request. Please submit this completed form and any supporting documentation to Molina Healthcare of Illinois.

Web Portal: Providers are strongly encouraged to use the Molina web portal to submit claim disputes.

Fax: The Claims Dispute Request Form can be faxed to Molina at (855) 502-4962. The fax must include the claims dispute request form.

Providers, please note: Please refer to the corrected claims form for submission guidelines on claims being corrected and not disputed.

☐ **HealthChoice Illinois** ☐ **HealthChoice Illinois MLTSS** ☐ **MMP (Dual Options)**

☐ Participating ☐ Not Participating

If not participating with MMP (Dual Options) please include the Waiver of Liability form with your dispute.

Number of faxed pages (including cover sheet) _____

Section 1: General Information

Claim Number: (one claim per form)		Member ID #:	
Member Name:		Date of Service:	
Provider Name:		Billed Charges ($):	Contact Person:
Provider ID (TIN):	NPI:	Provider Phone #:	Provider Fax # (Required*):

***NOTE: Dispute Resolution Letters will be returned to the fax number provided in this form.**

Section 2: Type of Claim Dispute Adjustment

Based upon the following reason(s), we are requesting reconsideration of this claim.

Category of Claim Dispute Provider: Please check applicable reason(s) and attach all supporting documentation.	
☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider/tax ID number
☐ **Coding/Bundling Edits:** Attach supporting documentation/ medical records (Documentation is required)	☐ **Timely Filing:** Attach claims & supporting documentation showing claim was filed to Molina in a timely manner
Coordination of Benefits Information: ☐ Alternate Insurance Information /EOP Attached ☐ COB – Related Adjustment Primary Insurance ☐ Retrospective Medical Review: Attach reason Prior Authorization was not obtained for service performed and attach medical records.	☐ **Payment Amount:** _____ ☐ **Claims Reversal Needed** Reason: _____ ☐ **Under/Overpayment –** Explain the reasoning: ☐ **Service is not a duplicate –** Explain the reasoning: ☐ **Pre-Authorization now on file – #** _____
Comments/Other:	
For Internal Use Only: Resolution: _____	