MOLINA® HEALTHCARE

Your Extended Family.

Appeal Representative Form

You must sign this form and send it back to Molina Healthcare. We cannot process your appeal until we receive this form. This form is very important because it gives us your written consent to appoint someone else to act on your behalf during the appeal process.

Member Name: _____

Member Address: _____

City, State, Zip: _____

Member Phone Number: _____

Member ID Number: _____

I, _____ , appoint _____ to act as my representative in requesting an appeal from Molina Healthcare of Ohio, Inc. regarding the termination, reduction, denial or suspension of medical service coverage.

→ Member Signature: _____

Date: _____

The signature above must be the member's signature. (A legal guardian or provider signature will not be accepted.)

Please submit to:

Molina Healthcare of Ohio, Inc.
Attn: Appeals Department
P.O. Box 349020
Columbus, OH 43234-9020

Fax: (866) 713-1891

Practitioners/Providers please note: While this appeal is in process you may not limit the member's access to services.