Claims Reconsideration Request Form

Requests for a Clinical Appeal must be submitted on a "Provider Clinical Appeal Request Form"

Number of faxed pages (including cover sheet): ______________________

Please return this completed form and any supporting documentation via fax to **(315) 234-9812**. Claim reconsiderations submitted without a completed form attached will be returned. Requests must be received within **90** days of the original remittance advice unless noted otherwise in your provider contract.

Provider Status (check): ☐ Participating Provider ☐ Non- Participating Provider

Providers: Please send corrected claims as normal claim submissions via electronic or paper submission. This includes claims with primary payer information and Explanation of Benefits (EOBs). Any corrected claims received as reconsiderations will be returned.

Section 1: General Information

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

Section 2: Type of Claim Adjustment

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

Type of Adjustment Request Provider: Please check applicable reason(s) and attach all supporting documentation	
☐ **Member:** Processed under incorrect member	☐ **Provider:** Processed under incorrect provider/ tax ID number
☐ **CCI Edits:** Attach supporting documentation/ medical records (documentation is required)	☐ **Timely Filing:** Attach claim & supporting documentation showing claim was filed to Molina in a timely manner
Coordination of Benefits Information: ☐ Alternative Insurance Information/ EOP attached ☐ COB- Related Adjustment Primary Insurance Carrier Information:	**Payment Amount:** ☐ Claims Reversal Needed- Reason: ______________________________ ☐ Under/ Overpayment- Reason: ______________________________ ☐ Service is not a duplicative- Reason: ______________________________ ☐ Pre-Authorization now on file- Auth #: ______________________________
Comments/ Other:	

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