Dispute Resolution Request Form

Provider Appeal Fax#: (877) 814-0342	Email: MHWProviderServicesInternalRep@MolinaHealthcare.com
Number of pages (including this cover sheet): ☐ First level Appeal ☐ Second level Appeal	☐ Medicaid ☐ Marketplace ☐ Medicare Par ☐ Medicare Non Par

General Information

Claim Number(s):	Date of Service:
Authorization #:	Billed Amount:
CPT/HCPC/Revenue Code:	
Member Name:	Member ID:
Provider Name:	
Contact Name:	Contact e-mail:
Contact Phone Number:	Contact Fax Number:

Type of dispute

☐ Correct Coding ☐ Duplicate ☐ Denied Authorization ☐ Underpaid/Overpaid ☐ Timely Filing ☐ COB ☐ Eligibility ☐ Invalid NDC ☐ Other ☐ No Prior Authorization – Select applicable extenuating circumstance below: Select Extenuating Circumstance
Reason for dispute:

Please return the completed form and submit all pertinent clinical documentation such as chart notes, lab results etc. Claim reconsiderations submitted without proper supporting documentation will be returned.

* Provider appeals may also be submitted electronically through the Provider WebPortal at www.Molinahealthare.com

CONFIDENTIALITY NOTICE: This communication, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this communication is prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately via telephone and destroy the original information.