Provider Claim Appeal and Dispute Form

☐ Clinical Appeal ☐ Claim Payment Dispute

Please submit this request by visiting our Provider Portal, fax to **(315) 234-9812 - Attention: Appeals & Grievances Department** or by mail to **Molina Healthcare of New York, Attention: Appeals & Grievances Department, 1776 Eastchester Road, Bronx, NY 10461.**

- Complete the form and **any new and/ or additional supporting documentation** (office notes, laboratory and radiology reports, brief medical history, treatment plan, etc.)
- Standard and Expedited Clinical Appeal Requests must be received within **60 calendar days** of the initial adverse determination.
- Claim Payment disputes requests must be received within **90 calendar days** of the original remittance advise unless noted otherwise in your provider contract.
- ***Any corrected claims received as claim disputes will be returned.*** Corrected claims must be received within **60 calendar days** from the original claim determination date. Corrected claims must be sent as normal claim submissions via electronic or paper submission. This includes claims with primary payer information and Explanation of Benefits (EOBs).

If you are filing a clinical appeal on behalf of a member you must complete the "Appeal Request Form For Denial of Services" that was included in your (and the members) Initial Adverse Determination Denial Notice.

Line of Business (check): ☐ Medicaid Managed Care ☐ Child Health Plus ☐ Molina Healthcare PLUS (HARP) ☐ Essential Plan

Provider Status (check): ☐ I am a participating provider ☐ I am a non-participating provider

Provider Representative (Check): ☐ Self ☐ Billing Agency ☐ Law Firm ☐ Other: _____

Request Type (check): ☐ Standard ☐ Expedited*

**If you indicate that this is an EXPEDITED request you are certifying that the standard 30-calendar-day time frame could jeopardize the life or health of the member or the member's ability to regain maximum function. (A decision will be made within 72 hours of receipt). For additional assistance with EXPEDITED appeals, please fax a completed form and then call the Appeals & Grievances Department at (877) 872-4716.*

Section 1: General Information

Member Last Name	**Member First Name**
Member Date of Birth	**Member CIN#**
Requesting Provider	**Requesting Provider Address**
Appeal Contact (First, Last Name)*	
Appeal Contact Direct Phone Number*	**Appeal Contact Fax Number***
Representative Contact Name	**Contact phone:**
Representatives Address	

**The Appeal Contact information is very important for our Appeals & Grievances Department to process your request in a timely fashion.*

Section 2: Claim/ Authorization Information

Claim number*	**Billed Charges ($)**	
Date of service*	**Authorization number***	
Date of denial	**TIN**	**NPI**

***These fields are mandatory and if not completed or accurate the information will be returned as unable to process. If you receive an unable to process any resubmissions will need to be done within the noted appeal/dispute timely filing deadlines at the top of the form.**

To ensure timely and accurate processing of your request, please complete the Payment Dispute section below by checking the applicable determination provided to you on either the Molina Healthcare Denial Notice or Explanation of Payment (EOP) and provide details in the other/ comments field.

Section 3: Payment Dispute

Clinical Appeals Only	Claim Payment Dispute
☐ Medical Necessity	☐ Code edits (supporting documentation required)
☐ Inpatient vs. Observation	☐ Incorrect Provider/ tax ID -NPI
☐ Not Prior Authorized	☐ Coordination of Benefits (COB)
☐ Benefits Exhausted	☐ Overpayment/Underpayment
☐ Out of Network	☐ Missing/Incorrect NDC/Invoice
☐ Not a Covered Benefit	☐ Untimely Timely filing (proof of timely filing must be included)
☐ Claim Not Billed as Authorized	☐ Non-Covered Codes
☐ Exceeds Authorization	☐ Eligibility
☐ Other/ Comments:	

Reason for Request:

Unless your contract allows otherwise, Molina Healthcare will pay the Medicaid allowable, depending on member's plan, for the service performed if we overturn our previous decision. By signing this form, you agree to these terms and will not bill the member, except for applicable co-pays or coinsurance.

Name: _____

Signature: _____ **Date:** _____