



Provider Appeal 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, 5232 Witz Drive, North Syracuse, NY 13212.**

- 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.
- 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). Any corrected claims received as claim disputes will be returned.

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* Project**

**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 1-877-872-4716.*

***Projects are defined as having 25 or more claims for the exact same dispute reason. Additional claim numbers should be listed in the Other/Comments in Section 3.*

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

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
<input type="checkbox"/> Medical Necessity	<input type="checkbox"/> Code edits (supporting documentation required)
<input type="checkbox"/> Inpatient vs. Observation	<input type="checkbox"/> Incorrect Provider/ tax ID -NPI
<input type="checkbox"/> Not Prior Authorized	<input type="checkbox"/> Coordination of Benefits (COB)
<input type="checkbox"/> Benefits Exhausted	<input type="checkbox"/> Overpayment/Underpayment
<input type="checkbox"/> Out of Network	<input type="checkbox"/> Missing/Incorrect NDC/Invoice
<input type="checkbox"/> Not a Covered Benefit	<input type="checkbox"/> Untimely Timely filing (proof of timely filing must be included)
<input type="checkbox"/> Claim Not Billed as Authorized	<input type="checkbox"/> Non-Covered Codes
<input type="checkbox"/> Exceeds Authorization	<input type="checkbox"/> Eligibility
<input type="checkbox"/> Other/ Comments:	
<input type="checkbox"/> Project: 25 or more claims with the exact same claim payment dispute. Specify issue:	

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: _____

CONFIDENTIALITY NOTICE: This fax transmission, 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 fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at (800) 223-7242 and destroy the original documents.