

## PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

Please complete the below form. Fields with an asterisk ( \* ) are required. Incomplete form will not be processed. Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. Provide additional information to support the description of the dispute.

### How to submit Provider Disputes and Appeals

**1. Molina’s Provider Portal (<https://provider.molinahealthcare.com>)**

- Most preferred and efficient method to submit a dispute/appeal is through Molina’s Provider Portal.
- Providers can search and locate the adjudicated claim on the Molina Portal and submit a dispute/appeal.
- Portal submission does not require this form (Provider Dispute Resolution Request form).

**2. Fax 562-499-0633**

- Faxing a dispute/appeal requires completion of this form (Provider Dispute Resolution Request form). Incomplete form will not be processed.
- Must include provider’s fax number to receive the resolution of the dispute via fax.
- Must include applicable supporting documents to justify a dispute/appeal, if applicable.

<b>*PROVIDER NAME:</b>		<b>*PROVIDER TAX ID # / Medicare ID #:</b>	
<b>*PROVIDER FAX</b> (fax number to receive the acknowledgment and resolution of the dispute):		<b>*Provider NPI</b>	
<b>*Contact Person Name:</b>		<b>*Phone Number:</b>	
<b>*Line of Business:</b> <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Marketplace <input type="checkbox"/> Medicare			
<b>* CLAIM INFORMATION</b> <input type="checkbox"/> Single claim <input type="checkbox"/> Multiple “LIKE” Claims – Multiple Like <i>must be same rendering provider and same claim issue</i> ( <a href="#">complete attached spreadsheet</a> ) <i>Number of claims</i>			
<b>* Patient Name:</b>		<b>*Patient Date of Birth:</b>	
<b>* Molina Member ID:</b>	<b>Patient Account Number:</b>	<b>*Molina Issued Original Claim ID</b> (if multiple claims, attach a spreadsheet)	
<b>*Service “From/To” Date:</b>	<b>Original Claim Amount Billed:</b>	<b>Original Claim Amount Paid:</b>	
<b>*Description of Dispute</b>			
<b>Expected Outcome</b>			

[ ] CHECK HERE IF ADDITIONAL INFORMATION OR PAGES ARE INCLUDED WITH THIS FORM