

Provider Claim Appeal and Dispute Form

☐ Clinical Appeal ☐ C	Claim Payment Dispute	е		
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, 2900 Exterior Street, Suite 202, Bronx, NY 10463.				
 notes, laboratory and Standard and Expendays of the initial action Claim Payment dispremittance advise to the initial action Any corrected claims received within 60 camust be sent as nor 	d radiology reports, bridited Clinical Appeal Riverse determination. Dutes requests must be inless noted otherwise is received as claim dispalendar days from the onal claim submissions view of the conal claim submissions view of the claim submissions v	in your provider contract putes will be returned. Co	tment plan, etc.) ed within 60 calendar endar days of the original et. errected claims must be en date. Corrected claims emission. This includes	
lf you are filing a clinical ap Form For Denial of Services Determination Denial Notic	" that was included in			
Line of Business (check):	☐ Medicaid Managed Care ☐ Child Health Plus ☐ Molina Healthcare PLUS (HARP) ☐ Essential Plan			
Provider Status (check):	☐I am a participating	g provider □l am a no	on-participating provider	
Provider Representative (Ch	eck): Self Billing	g Agency □Law Firm	Other:	
Request Type (check):	equest Type (check): Standard Expedited*			
*If you indicate that this is an frame could jeopardize the life (A decision will be made withi fax a completed form and the	or health of the member n 72 hours of receipt). For	or the member's ability to a additional assistance with	regain maximum function. EXPEDITED appeals, please	
Section 1: General Inforn	nation			
Member Last Name		Member First Name		
Member Date of Birth		Member CIN#		
Requesting Provider		Requesting Provider Ad	Idress	
Appeal Contact (First, Last Name)*				
Appeal Contact Direct Phone Number*		Appeal Contact Fax Nu	ımber*	
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
☐ 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:	

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.

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^{*}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.