Provider Claim Information Form

Please fax form to (888) 656-7501. If you have any questions, please contact Molina Healthcare at (800) 424-5891.

***Required field**

Provider Information

Authorization Tracking Number * _____

Record Type * _____ State/LOB Servicing * _____

NPI Number * _____ Social Security Number _____

Last Name (or Organization Name) * _____

First Name * _____ Middle Name/Initial _____

Primary Provider Specialty * _____ Title _____ Gender _____

Service Location Name * _____

Service Address 1 * _____

Service Address 2 _____

Service Address City * _____ Service Address State * _____

Service Address Zip Code * _____ Primary Address (Y/N) * _____

Medicaid ID * _____

Mailing Address 1 * _____

Mailing Address 2 _____

Mailing Address City * _____

Mailing Address State * _____ Mailing Zip Code * _____

Billing Entity Name * _____

Billing NPI Number * _____

Billing Tax ID Number * _____

Billing Address 1 * _____

Billing Address 2 _____

Billing Address City * _____

Billing Address State * _____ Billing Zip Code * _____