Provider Early Reversal Permission Form

Provider is requesting Molina Healthcare deduct the claim(s) paid in error from a future Remittance

Provider Name _____ Provider Tax Id Number _____

Person Requesting Claim(s) Reversal _____ Signature / Date _____

Claim Number	Overpayment Amount	Overpayment Reason

Comments _____

_____

_____

_____

Please fax to: Fax# 844.305.2186
Or Mail your refund with this form to:
Molina Healthcare Claims Recovery Department
PO Box 744627Atlanta, GA 30374-4627

Completed by (MHI staff) _____ **Date Reversals Completed** _____