MOLINA HEALTHCARE Healthy Connections PRIME

MOLINA DUAL OPTIONS APPEALS REQUEST FORM

(Requests must be received within 90 days of the original remittance advice).
Appeals processing time:
MMP Duals (PAR): **30** days
To save time, and receive an email confirmation, please submit your appeals online here:
https://provider.molinahealthcare.com
Send **Corrected Claims** to: Molina Healthcare of South Carolina
PO Box 22664 Long Beach, CA 90801
Please return this completed form and all supporting documentation via fax: (562) 499-0610 or mail: Molina Healthcare of South Carolina, Attn: Claims Disputes/Adjustments, PO Box 22816 Long Beach, CA 90801

LOB:	Participating or Non-Participating:

Section 1: General Information

Member Name:	Member ID #:	
Claim Number (s):	Date of Service:	Billed Charges ($):
Provider Name:	Provider TIN:	Provider NPI:
Contact Person:	Phone #:	Fax#:

Section 2: Type of Appeal

Provider: Please check the applicable reason(s) for the claim reconsideration and attach all supporting documentation.

❑ **Provider:** Processed under incorrect provider/Tax ID number.	❑ **Timely Filing:** Attach claim & supporting documentation showing claim was filed with Molina in a timely manner.
❑ **CCI Edits:** Supporting documentation/ medical records are required to process the reconsideration.	❑ **Pre-Authorization:** Now on file. Authorization #
❑ **Coordination of Benefits Related Adjustment** Primary Insurance Carrier information:	❑ **Claims Reversal Needed**: Explain the reasoning
❑ **Alternate Insurance Information** : EOB Attached	❑ **Under / Overpayment:** Explain the reasoning
❑ **Med Necessity:** Attach reason Prior Authorization was not obtained for service performed & medical records	❑ **Service is not a duplicate:** Explain the reasoning
Additional Details:	

** **If Molina Healthcare of South Carolina determines there is a system configuration error, a claim analysis will be conducted to pull impacted claims for reprocessing. Additional reconsiderations will not need to be submitted.** **