



Provider Appeal Form

All fields must be completed to successfully process your request. Missing or incomplete forms will not be processed and returned to the sender. Please attach all pertinent documentation to this form.

Claims Denied for Missing/Additional Documentation:

Claims denied for missing or additional documentation requirements such as consent forms, invoices, explanation of benefits from other carriers, or itemized bills are not considered claim appeals. To process your claim, these documents, along with a claim, must be received by the claims department within timely filing requirements. Do not include a provider appeal form with a claim submission. Please mail claims denied for missing or additional documentation to:

- Molina Healthcare of Nebraska
PO Box 93218
Long Beach, CA 90809-9994

Provider Appeal Submission Methods:

- Online Portal: <https://www.availity.com/molinahealthcare> (Preferred Submission Method)
- Fax: 1-833-832-1517
- Mail: Molina Healthcare of Nebraska, Inc.
Appeals & Grievances Unit
PO Box 182273
Chattanooga, TN 37422

Provider Information

Provider/Group Name:	NPI:
Contact Person:	Contact Phone # - Fax # - Email:

Member Information

Member Name:	Member ID:
--------------	------------

Claim Information

Claim ID (only one claim per appeal form):	
Authorization ID (if applicable):	
Billed Amount:	Date of Service:

Appeal Reason

<input type="checkbox"/> Benefit Limitation Exceeded	<input type="checkbox"/> Authorization/Medical Necessity
<input type="checkbox"/> Underpayment	<input type="checkbox"/> Bundling/Unbundling
<input type="checkbox"/> Untimely claim filing (Proof of timely filing must be included)	<input type="checkbox"/> Other

Comments:
