Senior Whole Health
BY MOLINA HEALTHCARE

Claim Reconsideration Request Form

Date: __ / __ / ____

- Please submit the request by our preferred method, visiting the **Provider Portal**, by visiting **https://www.availity.com/molinahealthcare**, or fax to:
  - Medicaid, Medicare, Dual SNP Post Claim: (562) 499-0610
- Attach all required supporting documentation.
- Incomplete forms will not be processed. Forms will be returned to the submitter.
- Please refer to the Molina Provider Manual for timeframes and more information.

Corrected Claims
Please send corrected claims as a normal claim submission electronically or via the **Provider Portal**. This includes attachments for COB or itemized statements.

Multiple Claims
If multiple claims with the same denial require an appeal, attach an Excel sheet.
Note: Multiple claims must be from the same rendering provider and for same claim denial reason.

Provider Information			
Contact Person		**Contact Phone #**	
Provider/Group Name			
Provider NPI		**Provider Tax ID/Medicare ID**	
Provider Phone #		**Provider Fax #**	

Member Information			
Member Name		**Member Account #**	
Member Date of Birth		**Molina Member ID**	

Claim Information				
Line of Business	☐ Medicaid	☐ Dual	☐ Medicare	☐ MAPD
Claim Information	☐ Single Claim		☐ Multiple Claims	
Molina Original Claim ID				
Original Claim Amount Billed				
Dates of Service				

Denial Reason (Mark all applicable)	
☐ **Duplicate Service**	☐ **Coordination of Benefits (COB)**
☐ **Processed under incorrect Provider/Tax ID**	☐ **Processed under incorrect member**
☐ **Overpayment/Underpayment**	☐ **National Correct Coding Initiative (NCCI) Edit**
☐ **Exceeded timely filing limit**	☐ **Eligibility**
☐ **Missing/Incorrect NDC**	☐ **Other (Please explain)**

Additional Information: