Molina Healthcare

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:

_____

_____

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_____

Return form to Molina Healthcare by:

Fax: Claims Recovery Department at (540) 645-6368; or

Mail: Molina Healthcare of Virginia. PO Box 2470. Spokane, WA 99210-2470

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