APPEAL REQUEST FORM

If you don't agree with the decision Molina Healthcare (Molina) has made on a service request or payment issue, you have the right to appeal. You may also file an appeal with the Department of Medical Assistance Services (DMAS) Appeals Division, but you must file an appeal with Molina first. You have 60 calendar days from the date on the service letter or payment decision to appeal in writing or by telephone. After 60 calendar days, it is too late to appeal the decision. Below is a form to assist you in making your appeal request in writing. You can provide it to us in person or mail to:

Appeals & Grievance
Molina Healthcare, Inc.
PO Box 36030
Louisville, KY 40233-6030
or
Fax: 1-866-325-9157

If you are in need of assistance completing this form please call Member Services from 8 a.m. to 8 p.m. local time, Monday through Friday.

Cardinal Care Managed Care: (800) 424-4518 (TTY: 711)

Member Name:	**Claim Number:**
Member ID:	**Member Date of Birth:**
Date of Service:	**Provider:**
Preferred Contact Phone Number:	
Preferred Address:	
Service(s) appealed:	
Are you requesting Continuation of Benefit? ☐ Yes ☐ No Please note that if the original adverse decision is upheld you may be responsible for paying for the care received during the appeal process**.** The Continuation of Benefit request must be received by Molina within 10 calendar days of the initial denial/reduction or within 10 calendar days of service end date.	
Reason for appeal: _____ _____	

Please send any additional information you would like us to consider in deciding your appeal.