



Claims Reconsideration Request Form

Requests for a Clinical Appeal must be submitted on a "Provider Clinical Appeal Request Form"

Number of faxed pages (including cover sheet): _____

Please return this completed form and any supporting documentation via fax to **(315) 234-9812**. Claim reconsiderations submitted without a completed form attached will be returned. Requests must be received within **90** days of the original remittance advice unless noted otherwise in your provider contract.

Provider Status (check): Participating Provider Non- Participating Provider

Providers: Please send corrected claims as normal claim submissions via electronic or paper submission. This includes claims with primary payer information and Explanation of Benefits (EOBs). Any corrected claims received as reconsiderations will be returned.

Section 1: General Information

Claim Number (one claim per form)		Member ID #	
Member Name		Date of Service	
Provider Name		Billed Charges (\$)	Contact Person
Provider TIN	Provider NPI	Provider Phone	Provider Fax #

Section 2: Type of Claim Adjustment

Based upon the following reason(s), we are requesting an adjustment of this claim.

Type of Adjustment Request Provider: Please check applicable reason(s) and attach all supporting documentation	
<input type="checkbox"/> Member: Processed under incorrect member	<input type="checkbox"/> Provider: Processed under incorrect provider/ tax ID number
<input type="checkbox"/> CCI Edits: Attach supporting documentation/ medical records (documentation is required)	<input type="checkbox"/> Timely Filing: Attach claim & supporting documentation showing claim was filed to Molina in a timely manner
Coordination of Benefits Information: <input type="checkbox"/> Alternative Insurance Information/ EOP attached <input type="checkbox"/> COB- Related Adjustment Primary Insurance Carrier Information:	Payment Amount: <input type="checkbox"/> Claims Reversal Needed- Reason: _____ <input type="checkbox"/> Under/ Overpayment- Reason: _____ <input type="checkbox"/> Service is not a duplicative- Reason: _____ <input type="checkbox"/> Pre-Authorization now on file- Auth #: _____
Comments/ Other:	
CONFIDENTIALITY NOTICE: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at (800) 223-7242 and destroy the original documents.	