MOLINA HEALTHCARE

Provider Early Reversal Permission Form

Provider is requesting Molina Healthcare to deduct the claim(s) paid listed below from a future Remittance

_____
State:

_____ _____
Provider Name Provider Tax Id Number

_____ _____
Person Requesting Claim(s) Reversal Signature / Date

Claim Number	Overpayment Amount	Overpayment Reason

Comments _____

_____

_____

_____

Please fax to the appropriate Cost Recovery number for the state of the member's enrollment.

AZ 888-656-7504	KY 866-314-4613	NV 702-866-9724	UT 888-396-1519
CA 888-396-1060	MA 781-451-3259	NY 844-305-2186	VA 540-645-6368
FL 888-396-1121	MI 888-396-1167	OH 888-396-1517	WA 888-396-1520
ID 844-834-2057	MS 844-891-2863	SC 877-480-1127	WI 877-902-1208
IL 855-260-8740	NM 888-396-1516	TX 888-396-1518	MAPD/MC 888-396-1163