Claim Dispute Request Form

Date: _____/_____/_____

- Please submit the request by visiting our **Provider Portal**, or fax to **(248) 925-1768**.
- 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.
- Appeals related to Authorizations should be submitted with a letter and medical records.

Corrected Claims

Please send corrected claims as a normal claim submission electronically or via the **Provider Portal**.

Do not use this form for claims denied for no Champs enrollment. Submit corrected claim electronically or via the **Provider Portal**.

Multiple Claims

If multiple claims with the same denial require dispute, 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**	
Provider Phone #		**Provider Fax #**	

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

Claim Information					
Line of Business	☐ Medicaid	☐ Marketplace	☐ Medicare	☐ MMP	☐ LTSS
Claim Information	☐ Single Claim		☐ Multiple Claims		
Molina Claim ID					
Claim Amount Billed					
Dates of Service					

Denial Reason (Mark all applicable)	
☐ **Eligibility**	☐ **Coordination of Benefits (COB)**
☐ **Code Edit Denials (Supporting documentation required)**	☐ **Missing/Incorrect NDC**
☐ **Overpayment/Underpayment**	☐ **Duplicate Service**
☐ **Exceeded timely filing limit**	☐ **Processed under incorrect Provider/Tax ID**
☐ **Approved Authorization now on file**	☐ **Other (Please explain)**

Additional Information: