Provider Early Reversal Permission Form

Provider is requesting Molina Healthcare to deduct the claim(s) paid in error 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: Molina Healthcare Claims Recovery Department at (877) 480-1127