# Provider Dispute/Appeal Form

Disputes/Appeals received with a missing or incomplete form may cause a delay in processing. Please attach all pertinent documentation to this form when submitting your Appeal/Dispute.

You may submit your request by visiting: Welcome to Molina Healthcare, Inc - ePortal Services

Or

**Additional submission methods:**

- Fax: (877) 553-6504
- E-mail: MFL_ProviderAppeals@Molinahealthcare.com
- Mail: Molina Healthcare of Florida, Attn: Appeal and Grievance Unit, PO BOX 36030, Louisville KY 40233-6030

**Claims Denied for Missing Documentation**

Claims denied for missing or additional documentation requirements such as consent forms, invoices, explanation of benefits from primary carrier, or itemized bills are not considered claim disputes. To process your claim appropriately and promptly, these documents, along with the claim, must be received within Federal and State timely filing requirements and/or your Provider Services Agreement. Please mail the documentation with the claim to:

**Molina Healthcare of FL**
**P.O. BOX 22812**
**Long Beach, CA 90801**

| | |
|---|---|
| Provider/Group Name: | NPI: |
| Contact Person: | Contact Phone #: |
| Affected Provider Service Address: | |
| Member Name: | Member ID: |
| Member DOB: | |
| Provider FL Medicaid ID: | Medical License #: Taxonomy: Tax ID: |
| Line of Business: ☐ MMA (Medicaid) ☐ Marketplace | |
| Molina Original Claim ID: | |
| Original Claim Billed Amount: | |
| Date of Service: | |

**Denial Reason**

| | |
|---|---|
| ☐Untimely claim filing (Proof of timely filing must be included) | |
| ☐Benefit Limitation Exceeded* | ☐Underpayment/Overpayment |
| ☐Authorization Issue/Medically Necessary* | ☐Other |
| Comments: | |

*Medical Records are required