Authorization Reconsideration Request Form (Authorization Appeal or Clinical Claim Dispute)

(Form required when submitting an Authorization Appeal or a Clinical Claim Dispute request)

Authorization Appeal or Clinical Claim Dispute (Authorization Reconsideration)

- A second review of a denied authorization within 60 days of the date of the denial/non-approval authorization (Pre claim) or,
- A second review of a denied authorization post-claim within 365 days of the date of service, or within 60 days of the remittance advice; whichever is later (Medicaid line of business)
- Changes in coding (Pre/Post Claim) within 60 days of the date of the denial
- Add on procedures (Pre/Post Claim) within 60 days of the date of denial
- Extenuating Circumstances Post Claim (as defined in the Provider Manual). Please note in your comments if there are extenuating circumstances.

Authorization Appeal (Pre-Claim Reconsideration)

Molina transitioned to a portal-only submission model for prior authorizations. Effective Jan. 1, 2026, providers are required to use the Availity Essentials portal for prior authorization submission. For a pre-claim submission, you will resubmit as a new authorization with the supporting documentation and state that it is a reconsideration.

- Register for the Availity Essentials portal at availity.com/MolinaHealthcare/
- Log into the Availity Essentials portal at availity.com/providers/

Clinical Claim Dispute (Post-Claim Reconsideration)

Please upload this completed form and any supporting documentation through the following methods:

- Availity Essentials Portal Appeal Process (via the Claim Inquiry process and select Claim Payment Dispute/Appeal)
- Verbally (Medicaid/MyCare Ohio): (855) 322-4079
- Post-Claim Fax: (800) 499-3406
- Medicare Non-Par Fax: (562) 499-0610

Authorization ID: _____ Claim ID: _____

Member Information	
Member Name:	Date of Denial/Non-approval:
Member ID:	Service Request:
Date of Birth (DOB):	

Provider Information	
Provider Name:	Phone Number:
Facility Name:	Fax Number:
Contact Name:	Disc Password (if applicable):

Please send clinical notes and any supporting documentation. Please refer to your denial rationale for specific information required.

- Related diagnostic testing
- Treatments tried, and the effect and outcome
- Assessment and/or evaluation notes
- For Home Health, service notes and OASIS Form/485

This form is not intended to be used for Non-Clinical Claim Disputes, such as administrative denials and coding edits.