PO Box 182273
Chattanooga, TN 37422

PROVIDER CLAIMS DISPUTE REQUEST FORM

Molina Healthcare of Idaho

Provider Information:

Provider Name: _____

NPI# _____

Contact Person: _____

Phone: _____Fax: _____

Mailing Address: _____

_____

Claim Number: _____

DOS: _____

Member Name: _____

Member ID Number: _____DOB_____

Reason for Request:

Please include a copy of the EOB with the appeal and any supporting documentation.
Please fax request to**: 877-682-2218**/ Attn: Appeals