PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Provider Appeal Form

☐ Medicaid ☐ Marketplace

All fields must be completed to successfully process your request.
Provider appeals and provider claim appeals received with a missing or incomplete form will not be processed and returned to sender. Please attach all pertinent documentation to this form.

Appeal Submission Methods:

- Fax: 1-866-315-2572
- Online Portal: www.Availity.com
- Email: MHK_Provider_GnA@molinahealthcare.com
- Mail: Passport Health Plan by Molina Healthcare
  Attention: Provider Appeals
  PO BOX 36030
  Louisville, KY 40233

Claims Denied for Missing Documentation:
Claims denied for missing or additional documentation requirements such as consent forms, invoices, explanation of benefits from other carriers, or itemized bills are not considered claim appeals. In order to process your claim appropriately and promptly, these documents, along with a claim, must be received within timely filing requirements. Do not include a provider appeal form with your request.

Please mail to:

KY Medicaid Claims Passport Health Plan by Molina Healthcare PO BOX 36090 Louisville, KY 40233	KY Marketplace Claims Passport Health Plan by Molina Healthcare PO BOX 43433 Louisville, KY 40253

Provider Information	
Provider/Group Name:	NPI:
Contact Person:	Contact Phone #:
Member Information	
Member Name:	Member ID:
Claim Information/Authorization Information	
Claim ID:	
Billed Amount:	
Date of Service:	
Authorization ID (If Applicable):	
Appeal Reason	
☐Untimely claim filing (Proof of timely filing must be included)	
☐Coding	☐Payment Dispute
☐Authorization	☐Other/Comments: