



# Claim Reconsideration/Adjustment Form

# of pages (including CAF cover sheet) \_\_\_\_\_

Name of Provider: \_\_\_\_\_

Molina Healthcare TIN # \_\_\_\_\_

Date: \_\_\_\_\_

Member Name	Member ID #	Date of Service		Service Code	Pending Balance	Claim #
		To	From			
1						
2						
3						
4						
5						
6						
7						
8						

<b>Reasons:</b> 1 Reimbursement Difference 2 Authorized Dates 3 Authorization Service # 4 Resubmission with original attached 5 Pending Payment 6 Other Reasons (Explain)	<b>Comments:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____
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\_\_\_\_\_  
Signature of Contractor's Name                      Date

- |  |   |
|--|---|
| 1. Write only claims that are partially paid or denied and re-submit this form with supporting documents.<br>a. Copy of the Molina Remittance Advice<br>b. Copy of the Original Invoice<br>c. Other requesting documents | 2. To mail completed Claims Adjustment Form and Claims, please mail to:<br>Attention: Texas Claims<br>P.O. Box 165089<br>Irving, TX 75016 |
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