CLAIMS

Please submit claims for Molina Healthcare Medicaid and MIChild to:

Billing Address:

Molina Healthcare
P.O. Box 22668
Long Beach, CA 90801

Please do not submit initial claims to the Troy address as this will delay the processing of your claims, and your claim may be returned. Please contact Member/Provider Contact Services for claims status information at 1-888-898-7969, Monday – Friday 8:00 a.m. – 6:00 p.m. EST; you may inquire about 3 claims per call. Please have the Member ID, Date of Service, Tax ID, and/or Claim Number ready when calling to ensure timely assistance.

Claims Submission Guidelines

Filing Limit

- Claims should be sent to Molina Healthcare within 90 days from the date of service.
- For resubmission or secondary claims, Molina Healthcare must receive the claim within 180 days from the date of service.
- If a claim is submitted to Medicaid or another HMO in error prior to the claim being submitted to Molina Healthcare, the submission limit is not extended. Eligibility must be verified prior to rendering services.
- Molina Healthcare responds to claims within State processing guidelines. The Claims determination will be reported to the provider on a Remittance Advice (RA).
- If no response is received within 45 days on a submitted claim, please call Member/Provider Contact Services at 1-888-898-7969, or use WebPortal to status the claim(s).
- All claims received beyond the timely filing will be rejected and members may not be billed for the services.

Electronic Claims Submission

Molina Healthcare accepts claims electronically, including secondary claims. Electronic submission allows claims to be directly entered into Molina Healthcare's processing system, which results in faster payment and fewer rejections.

- WebPortal (www.molinahealthcare.com) Provider Self Services
  - submit claims
  - status claims
  - print claims reports

Molina Healthcare also accepts electronic claims submissions through the following clearing houses:

- Emdeon (formerly WebMD) – Payer Number is 38334
- Practice Insight (HCFA 1500 only) – Payer Number is 38334

Contact Information

- For WebPortal access contact Molina Healthcare's Help Desk at 1-866-449-6848 or contact your Provider Services Representative directly.

- For EDI claim submission issues contact Molina Healthcare's Help Desk at 1-866-409-2935 or submit an e-mail to EDI.Claims@MolinaHealthcare.com. Please include detailed information related to the issue and a contact person's name and phone number.

Claim Forms

- Professional charges must be submitted on a CMS 1500 08-05 version form
- Facility UB04 Form

Paper Claim Submission Guidelines

- Must use original forms
- Must be typewritten or computer generated
- Do not use highlighters, white-out or any other markers on the claim
- Avoid script, slanted or italicized type. 12 point type is preferred
- Do not use an imprinter to complete any portion of the claim form
- Do not use punctuation marks or special characters
- Use a six digit format with no spaces or punctuation for all dates (ex121511).
- Securely staple all attachments. Attachments should identify patient's name and recipient ID number

Claims submission guidelines for Dual Eligible Members

Services provided to patients who are covered by Molina Healthcare please follow the guidelines listed below:

- Molina Medicare Options Plus and Molina Medicaid
  - Submit one authorization request - Molina Healthcare will coordinate authorization requirements, benefits and services between the two products
  - Submit one claim to Molina Healthcare - Upon receipt of the claim, we will process under Molina Medicare Options Plus then Molina Medicaid. There is no need to submit two claims. Claims processing information will be reported on two Remittance Advice (RA) forms
    - The 1st will come from Molina Medicare indicating how the claim was processed and informing you that the claim was forwarded to Molina Medicaid for secondary processing
    - The 2nd RA will show how the claim was processed for Molina Medicaid

- Molina Medicare and Fee-for-Service Medicaid
  - The provider must submit claim to Molina Medicare as primary for all services rendered.
  - Once the provider receives the remittance advice (RA) from Molina Medicare they must submit claim with primary payment details, which may include a copy of the Molina Medicare RA, to FFS Medicaid.

- Fee-for Service Medicare and Molina Medicaid
  - The provider must submit claim to FFS Medicare as primary for all services rendered.
  - Once the provider receives RA from FFS Medicare, they must submit claim with FFS Medicare payment detail to Molina Medicaid according to EDI specifications.
  - A hard copy of the RA must be submitted with all paper claim submissions.

Claims Policies

Adjudication

Molina Healthcare follows the State of Michigan Medical Services Administration (MSA) policies and procedures for adjudicating claims accordingly. Like all other health insurers, Molina applies nationally standard code edits and other claim logic. These edits are based upon national payment standards such as the CMS (Centers for Medicare & Medicaid Services) Correct Coding Initiative, edits internal to Ambulatory Payment Classification (APC) rules, the UB-04 Editor, the AMA (American Medical Association) CPT manual, and medical specialty organizations. These standards are monitored and updated periodically to properly apply the edits based upon the date of service.

Reference the Uniform Billing Guidelines, ICD-9 Diagnosis Code Book, CPT Code Book, HCPCS and Michigan Department of Community Health (MDCH) website www.michigan.gov when submitting a claim.

Payment

- Contracted providers will be paid according to the terms of the agreement between the provider and Molina Healthcare
- Non-Contracted Providers will be paid for covered services according to the MDCH Medicaid fee schedule in effect at the time of service.

Resubmission

- Providers may resubmit claims with correction(s) and/or change(s), either electronically or paper.
- For Paper CMS 1500 claim form: Enter "RESUBMISSION" on the claim in the Remarks section (Box 19) of the form.
- For Paper UB04 claim form: Type of bill must be indicated on the form. Enter "RESUBMISSION" in the comments section (Box 80) of the form.

Please send to Original/Resubmission to the address above, or submit electronically when appropriate and with appropriate bill type on UB 04 forms. Faxed copies are not accepted.

Interim Bills

Molina Healthcare does not accept claims billed with an interim bill type for outpatient services, containing a 2, 3, or 4 in the 3rd digit. All claims must be billed with the "admit through discharge" information. In the case of continuing or repetitive care, such as with physical therapy, facilities must bill on a monthly basis with all services occurring billed on one claim, with service from and to dates listed separately per line, and as an admit through discharge bill.

Newborn Care

Newborn care must be submitted on the appropriate claim form using the newborn's Medicaid ID number. The mother's Medicaid ID number may not be used to bill for services provided to a newborn.

National Drug Code (NDC)

Effective immediately per the MSA 10-15 and MSA 10-26 Bulletin regarding the billing of drug codes along with the appropriate NDC code for reimbursement. Submitting claims with a missing or invalid NDC drug code will result in delay of payment and/or denied claim. Please refer to newest NDC coding guidelines for direction regarding appropriate codes. Also refer to the Michigan Department of Community Health's (MDCH) bulletins MSA -7-33 and MSA 07-61 from 2007 and 2008 directing providers to bill accordingly.This requirement is mandated to ensure MDCH compliance with the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148.

Timely Filing Appeals

- Timely Filing appeals must be submitted with supporting documentation showing claim was filed in a timely manner.
- Complete a Claims Adjustment Request Form, or submit an appeal letter with supporting documentation.
- Mail your Timely Filing appeal to:

  Molina Healthcare
  Attention: Claims Department
  100 W. Big Beaver Road, Suite 600
  Troy, MI 48084-5209
- **Or fax to : 248- 925- 1768 Attention Timely Filing appeal**

Code Edit Appeals (CCI Edits)

- CCI Edit appeals must be submitted with supporting documentation and medical notes/reports.
- Only submit non corrected claims as appeals
- Complete a Claims Adjustment Request Form, or submit an appeal letter with supporting documentation.

- Mail your CCI Edit appeal to:

  Molina Healthcare
  Attention: Claims Department
  100 W. Big Beaver Road, Suite 600
  Troy, MI 48084-5209
- **Or fax to : 248- 925-1768 Attention CCI Edit appeal**

Rapid Dispute Resolution

Plan supports the Michigan Department of Community Health (MDCH) Rapid Dispute Resolution Process (RDRP) for hospitals under the MDCH Access Agreement. The purpose of this policy and procedure is to ensure Provider disputes are processed in a timely and efficient manner with adherence to State/Federal Regulations. Provider disputes will be reviewed to determine the appropriate resolution.

Provider National Identification Number (NPI)

Molina Healthcare Required Fields:

CMS 1500	Required?	Field Location
Billing Provider NPI	Yes	Box 33a
Billing Provider Medicaid Number	Yes	Box 33b
Rendering Provider NPI	Yes	Box 24j
Rendering Provider Medicaid Number	Yes	Box 24j
Referring Provider NPI	If Applicable	Box 17b
Facility Provider NPI	If Applicable	Box 32a
Taxonomy Code	No	Boxes 24j; 33b and 32b
UB04	**Required?**	**Field Location**
Billing Provider NPI	Yes	Box 56
Billing Provider Medicaid Number	Yes	Box 57a
Attending Provider NPI	If Applicable	Box 76
Operating Provider NPI	If Applicable	Box 77j
Other Provider NPI	If Applicable	Box 78
Other Provider NPI	If Applicable	Box 79
Taxonomy Code	No	Boxes 57, 76,77,78 and 79

Coordination of Benefits

As a provider treating Molina Healthcare members, your cooperation in notifying Molina Healthcare when any other coverage exists is appreciated. This includes other health care plans and/or any other permitted methods of third party recovery for coordination of benefits, worker's compensation, and subrogation.

- Claims involving coordination of benefits with primary insurance carriers should be received by Molina Healthcare within 365 days from the date of the primary carrier's explanation/denial of benefits.
- If Molina Healthcare reimburses a provider and then discovers other coverage is primary, Molina Healthcare will recover the amount paid by Molina Healthcare.
- Regardless of the primary payer's reimbursement, Molina Healthcare should be billed as a secondary payer for all services rendered. A copy of the primary payer's EOB showing payment or denial must be attached to the claim when submitting payment, or the claim can be submitted electronically for secondary coordination.
- Molina Healthcare will make payment if the primary insurance payment is less than the Medicaid Fee for Service Rate.
- Molina Healthcare members cannot be billed for any outstanding balance after Molina Healthcare makes payment.
- Molina Healthcare members do not have deductibles, co-pays or co-insurance.

Claim Request Forms

- **See Attachment A for Claims Adjustment Request Form and Instructions**
- **See Attachment B for Claim Status Form Example and Instructions**
    - **For the Claim Status Form Template please refer to the Forms Section on the website.**

Claim Form Field Requirements

- See Attachment C for CMS HCFA 1500 08-05 claim form requirements
- See Attachment D for CMS 1450 UB-04 claim form requirements

Sample Remittance Advice (RA)

- See Attachment E

MOLINA HEALTHCARE

Claims

Attachment A

MOLINA HEALTHCARE

Claims Adjustment Request Form

NOTE: FAILURE TO COMPLETE THIS FORM WILL RESULT IN A DELAY OF PROCESSING YOUR REQUEST

Please allow 45 day to process this adjustment request

☐ Medicaid Line of Business ☐ Medicare Line of Business ☐ MIChild Line of Business

Please return this complete form and any supporting documentation to:
Molina Healthcare of Michigan, 100 W. Big Beaver Road, Suite 600 Attn: Claims, Troy, MI 48084-5209
Or Fax to: (248) 925-1768. Please contact our Provider Services Call Center at 1-888-898-7969.
PROVIDERS NOTE: Please send Corrected Claims as normal submissions via electronic or paper.

Section 1: General Information

Today's Date	No. of Claims	Claim Number	
Member Name		Member Id#	
Provider Name		Date of Service	
Provider ID (TIN)	NPI	Provider Phone #	Contact Person

Section 2: Type of Claim Adjustment

Based upon the following reasons, we are requesting reconsideration of this claim.
Provider: Please check applicable reason(s) and attach all supporting documentation.

Appeals

☐ CCI Edits (documentation required)
Attn: CCI Edits Appeal
Fax to: 248-925-1768

☐ **TIMELY FILING:**
Use to appeal claims denied past one year filing limit.
Attach claim & supporting documentation showing claim was filed in a timely manner.
Attn: Timely Filing Appeal
Fax to: 248-925-1768

Coordination of Benefits Information

☐ Alternate Insurance Information / EOP Attached
☐ COB-Related Adjustment
Primary Insurance Carrier Information:_____
_____

Member

☐ Processed under incorrect member

Payment Amount

☐ Under / Overpayment – Explain the reasoning
_____
☐ Service is not a duplicate-Explain the reasoning
_____
☐ Pre-Authorization now on file - #_____
☐ Claims Reversal Needed: Reason_____
_____

Provider

☐ Processed under incorrect provider/provider tax identification number. (W-9 required) Should be:
Provider: _____
Tax Id: _____

Comments _____
_____
_____

For Internal Use Only:

Completed by:_____ Date: _____ Letter Sent: (circle one) Yes or No Date Letter was sent: _____

Additional Comments: _____ ☐ C/T ☐ HC-Corp

Claims Adjustment Request Form Instructions

Please indicate the Line of Business

SECTION 1: General Information

1. If preferred, save the form to your own computer

2. Complete each box in Section 1

3. Use one form per claim number

4. If submitting multiple claim adjustments for the same adjustment type, then complete only one Claims Adjustment Request Form, and leave the following fields blank (these fields will be on each of the claims):
   - Claim Number (can be indicated on each claim or submit the RA)
   - Member Name
   - Member ID #
   - Date of Service

5. Please do not alter this form, as it will not be accepted

SECTION 2: Type of Claim Adjustment
PLEASE CHECK THE MOST APPROPRIATE BOX

1. **Appeals:**
   - CCI Edits and Timely Filing appeals must be submitted with supporting documentation.

2. **COB:**
   - Requires a copy of primary payer EOB (explanation of benefits).
   - Requires effective date and/or term date, contract/policy number, and name of primary carrier.
   - Or send electronically with completed fields according to the EDI file layout.

3. **Member:**
   - **a.** Indicate processed under incorrect member of the provider practice.

4. **Payment Amount**
   - Requires supporting documentation of the calculation/formula used to determine amount of under/overpayment.
   - Indicate if a request for a reversal is to be completed for overpayments.
   - Requires a copy of the claim and supporting documentation for all duplicate claims.
   - Requires a copy of authorization for all authorization related issues.

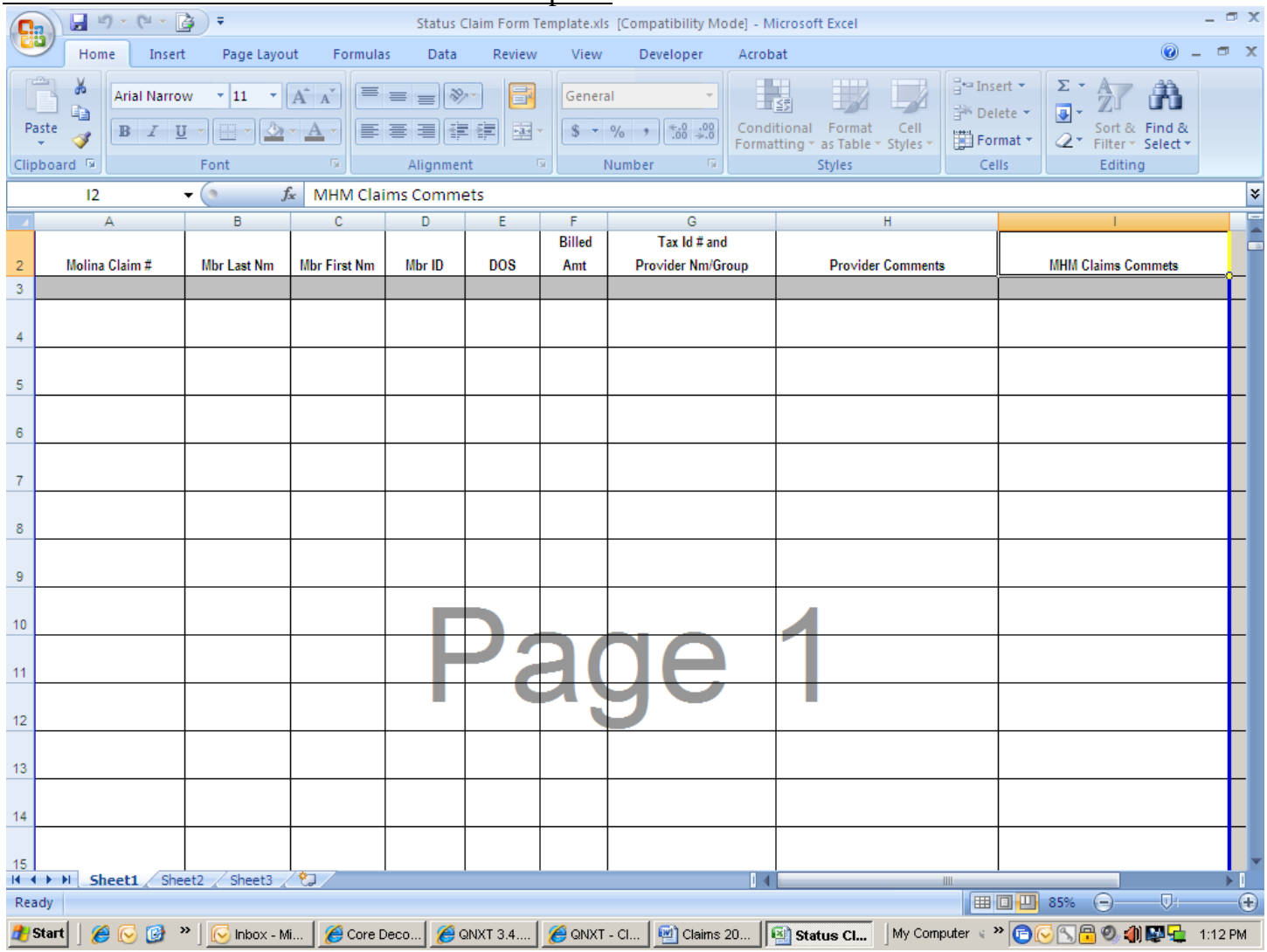
Please use additional paper attachments if necessary to document comments.
Fax form and documentation attention: **Claims Department** at (248) 925-1768 or mail to:

Molina Healthcare of Michigan
100 W. Big Beaver Rd, Suite 600
Attention: **Claims Department**
Troy, MI 48084-5209

Revised January 2012

Screen Print of Claim Status Form Template

Please refer to Forms Section for the Template



Claim Status Form Instructions

This form should be completed when the request to status more than 10 claims.

Enter the current date.

Enter the contact person in case there are questions.

Enter the contact phone number.

Claim number should be given if known.

Member Last and First names are optional, but is required with Date of Birth when member ID is not known.

Member ID number is required.

Date of Service (DOS), Billed Amount, Provider Name and TID, Rev/CPT, are required.

Use as many status sheets as necessary to document the inquiries.

Status forms will be completed within 15 business days from date received.

Fax Status Claim Form attention: **Claims Department** at (248) 925-1768 OR mail to:

Molina Healthcare of Michigan
100 W. Big Beaver Rd. Suite 600
Attention: **Claims Department**
Troy, MI 48084-5209

Attachment C

CMS HCFA 1500 08-05 claim form requirements

- MANDATORY: Item is required for all claims. If the item is left blank, the claim cannot be processed.
- CONDITIONAL: Item is required if applicable. Your claim may not be processed if blank.

FIELD	STATUS	INFORMATION
1	CONDITIONAL	Insurance
1a	MANDATORY	Medicaid I.D. Number (When billing for a newborn, the newborn's Medicaid ID is required by Molina Healthcare)
2	MANDATORY	Patient's Name
3	MANDATORY	Patient's Birth Date And Sex
4	CONDITIONAL	Insured's Name
5	CONDITIONAL	Patient's Address
6	CONDITIONAL	Patient Relationship To Insured
7	CONDITIONAL	Insured's Address
8	CONDITIONAL	Patient Status
9	CONDITIONAL	Other Insured's Name
9a	CONDITIONAL	Other Insured's Policy Or Group Number
9b	CONDITIONAL	Other Insured's Date Of Birth And Sex
9c	CONDITIONAL	Employer's Name Or School Name
9d	CONDITIONAL	Insurance Plan Name Or Program Name
10a	MANDATORY	Is Patient's Condition Related To Employment?
10b	MANDATORY	Is Patient's Condition Related To Auto Accident?
10c	MANDATORY	Is Patient's Condition Related To Other Accident?
10d	CONDITIONAL	Reserved For Location Use
11	CONDITIONAL	Insured's Policy Group Or Federal Employee Compensation Act (FECA) Number
11a	CONDITIONAL	Insured's Date Of Birth
11b	CONDITIONAL	Employer's Name Or School Name
11c	CONDITIONAL	Insurance Plan Name Or Program Name
11d	CONDITIONAL	Is There Another Health Benefit Plan?
12	CONDITIONAL	Patient's Or Authorized Person's Signature
13	CONDITIONAL	Insured's Or Authorized Person's Signature
14	CONDITIONAL	Date Of Current Illness, Injury Or Pregnancy
15	CONDITIONAL	If Patient Has Had A Same Or Similar Illness, Give First Date
16	CONDITIONAL	Dates Patient Unable To Work In Current Occupation
17	CONDITIONAL	Name Of Referring Physician Or Other Source
17a	CONDITIONAL	I.D. Number Of Referring Physician
17b	CONDITIONAL	10-digit NPI# of Referring Physician or Other Source
18	CONDITIONAL	Hospitalization Dates Related To Current Services
19	CONDITIONAL	Reserved For Local Use - Indicate the additional NDC's and its information in a claim attachment. Report "see attachment" IN THIS FIELD. Please refer to MSA 07-33 for Electronic Billing Information
20	CONDITIONAL	Outside Lab/Charges
21	MANDATORY	Diagnosis Or Nature Of Illness Or Injury
22	CONDITIONAL	Medicaid Resubmission Code And Original Reference Number
23	CONDITIONAL	Prior Authorization Number
24a	MANDATORY	Date(S) Of Service
24b	MANDATORY	Place Of Service
24c	CONDITIONAL	Type Of Service
24d	MANDATORY	Procedures, Services Or Supplies - Report the first NDC and its

FIELD	STATUS	INFORMATION
		information within the shaded supplemental service line.
24e	MANDATORY	Diagnosis Code (Pointer)
24f	MANDATORY	Charges
24g	MANDATORY	Days Or Units
24h	CONDITIONAL	EPSDT/Family Plan
24I	MANDATORY	EMG-Emergency - Y Or N
24j*	MANDATORY	Rendering Provider ID #, Medicaid # and NPI#
24k	CONDITIONAL	Reserved For Local Use
25	MANDATORY	Federal Tax I.D. Number (Check Box/SSN Or EIN)
26	MANDATORY	Patient's Account Number
27	CONDITIONAL	Accept Assignment
28	MANDATORY	Total Charge
29	CONDITIONAL	Amount Paid
30	MANDATORY	Balance Due
31	MANDATORY	Signature Of Physician Or Supplier Including Degrees Or Credentials
32	CONDITIONAL	Name And Address Of Facility Where Services Were Rendered (If Other Than Home Or Office)
32a	CONDITIONAL	10-digit NPI# of Service Facility Location
33	MANDATORY	Company Name as registered with IRS, Address, Zip Code, Phone # and PIN # (Medicaid ID # without Provider Type). Molina Healthcare requires the name registered with the IRS to be submitted on line one in Box 33.
33a	MANDATORY	10 digit NPI# of Billing Provider
33b*	MANDATORY	Billing provider Medicaid ID#

*Taxonomy code not required

Attachment D

UB-04 claim form requirements

- MANDATORY: Item is required for all claim submissions.
- CONDITIONAL: Item is required if applicable.

FIELD	STATUS	INFORMATION
1	MANDATORY	Company Name as registered with the IRS, Address and Telephone Number
2		Blank
3	MANDATORY	Patient Control Number
4	MANDATORY	Type of Bill
5	MANDATORY	Federal Tax Number
6	MANDATORY	Statement Covers Period
7		Blank
8a	MANDATORY	Patient Name
9a-d	MANDATORY	Patient Address
10	MANDATORY	Patient Date of Birth
11	MANDATORY	Patient Sex
12	MANDATORY	Admission Start of Care Date
13	MANDATORY	Admission Hour (for inpatient only)
14	MANDATORY	Type of Admission
15	MANDATORY	Source of Admission (SRC)
16	CONDITIONAL	Discharge Hour
17	MANDATORY	Patient Status (Discharge Status)*
18-28	CONDITIONAL	Condition Codes (if applicable)
29-30	CONDITIONAL	ACDT State
31-34	CONDITIONAL	Occurrence Codes and Dates (if applicable)*
35-37	CONDITIONAL	Occurrence span code
38a-d	CONDITIONAL	Name and Address of the party responsible for the bill
39-41 a-d	CONDITIONAL	Value Codes and Amounts (if applicable)*
42	MANDATORY	Revenue Codes*
43	MANDATORY	Revenue Description plus (First NDC & its supplemental information) Please refer to MSA 07-61 for Electronic Claim Format Information
44	MANDATORY	HCPCS Code/Rates (if applicable)
45	MANDATORY	Date of Service for the Line Item
46	CONDITIONAL	Units of Service (if more than 1)
47	MANDATORY	Total Charges (by Revenue Code/HCPCS)
48	CONDITIONAL	Dollar Amount for Any Non-covered Services
49		Blank
50	MANDATORY	Payer Identification
51	MANDATORY	Provider Number: Medicaid ID Number without the Provider Type
52	CONDITIONAL	Assigned Release For Insurance Benefit
53	CONDITIONAL	Assignment Of Benefits
54	CONDITIONAL	Prior Payments (if applicable)
55	MANDATORY	Estimated Amount Due From Payer
56	MANDATORY	Billing Provider NPI#
57	MANDATORY	Billing Provider Medicaid Number
58	CONDITIONAL	Name Of Insured
59	CONDITIONAL	Patient's Relationship To Insured
60	MANDATORY	Medicaid Recipient ID Number (When billing for a newborn, the newborn's Medicaid ID is required by Molina Healthcare).

FIELD	STATUS	INFORMATION
61	CONDITIONAL	Name Of Group Or Plan Through Which Health Insurance Is Provided
62	CONDITIONAL	Group Policy Number
63	CONDITIONAL	Pre-Cert Or Authorization Number
64	CONDITIONAL	Document Control Number
65	CONDITIONAL	Name Of Employer
66	MANDATORY	ICD-9 Principle Diagnosis
67a-q	CONDITIONAL	Other Diagnosis Codes (if applicable)
68		Blank
69	MANDATORY	Admitting Diagnosis (for Inpatient only)
70 a-c	CONDITIONAL	Patient Reason Diagnosis
71	CONDITIONAL	
72	CONDITIONAL	External Cause Of Injury ICD-9 Diagnosis Code
73		Blank
74	CONDTIONAL	Principle Procedure Code and Date
74 a-e	CONDITIONAL	Other Procedure Codes and Dates
75		Blank
76	CONDITIONAL	Attending Provider NPI#
77	CONDITIONAL	Operating Provider NPI#
78-79	CONDITIONAL	Other Provider NPI#
80	CONDITIONAL	Remarks (if applicable)

*Refer to Uniform Billing Manual for List of Codes

Sample Remittance Advice (RA)

MOLINA HEALTHCARE

Remittance Advice for
PO BOX , Oak Park MI 48237

TAX ID #

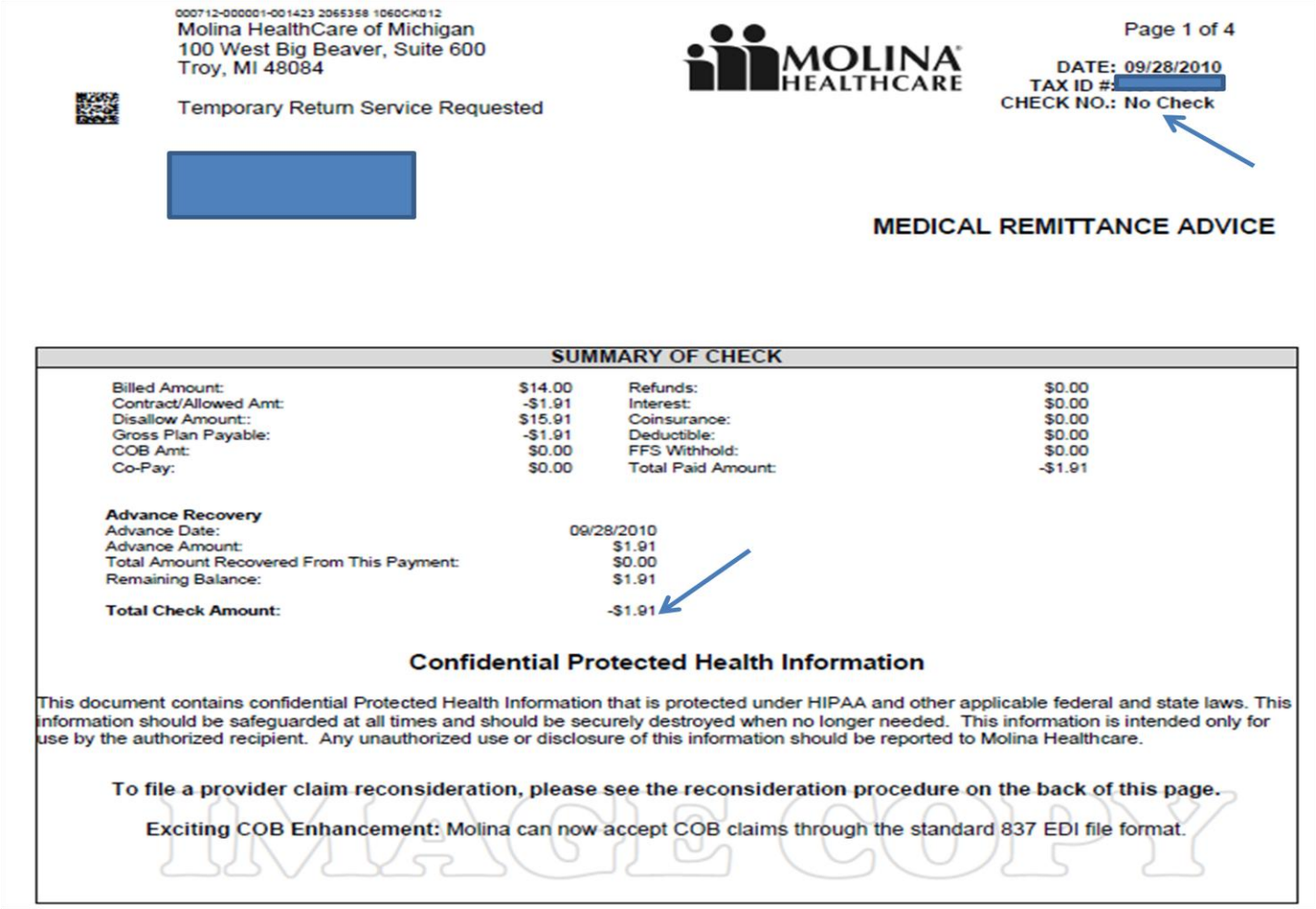
Molina Healthcare of
Michigan, Inc

Paid Date: 08/12/2010

Check #

Claim Line	Date of Service	Rev Code	CPT/ HCPC	Units	Modifier	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Other Disc/Int	Coinsurance	Deductible	FFS Withhold	Net Plan Payable	FFS/ CAP	Line Status	Expl Code
Patient Name:								Member ID#:				Claim #:				Patient Account #:				
Rendering Provider Name:								NPI#:				Program:	Michigan Medicaid							
1	07/30/2010		99238	1		$105.00	$37.04	$67.96	$37.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.04	FFS	PAID	
TOTAL AMOUNT:						$105.00	$37.04	$67.96	$37.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$37.04			
Patient Name:								Member ID#:				Claim #:				Patient Account #:				
Rendering Provider Name:								NPI#:				Program:	Michigan Medicaid							
1	07/29/2010		99222	1		$160.00	$59.02	$100.98	$59.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.02	FFS	PAID	
TOTAL AMOUNT:						$160.00	$59.02	$100.98	$59.02	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$59.02			

No check voucher
Cash Advance – Balance ($1.91)



000712-000001-001423 2065358 1060CK012
Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

Temporary Return Service Requested

[redacted]

Page 1 of 4

DATE: 09/28/2010
TAX ID #: [redacted]
CHECK NO.: No Check

MEDICAL REMITTANCE ADVICE

SUMMARY OF CHECK

Billed Amount:	$14.00	Refunds:	$0.00
Contract/Allowed Amt:	-$1.91	Interest:	$0.00
Disallow Amount::	$15.91	Coinsurance:	$0.00
Gross Plan Payable:	-$1.91	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	-$1.91

Advance Recovery

Advance Date:	09/28/2010
Advance Amount:	$1.91
Total Amount Recovered From This Payment:	$0.00
Remaining Balance:	$1.91
Total Check Amount:	-$1.91

Confidential Protected Health Information

This document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Exciting COB Enhancement: Molina can now accept COB claims through the standard 837 EDI file format.

IMAGE COPY

Detail of no check voucher
Cash advance of ($1.19)

MOLINA HEALTHCARE

Remittance Advice for [redacted]

TAX ID # [redacted]

Molina Healthcare of Michigan, Inc

Paid Date: 09/28/2010 Check # No Check

Claim Line	Date of Service	Rev Code	CPT/ HCPC	Units	Modifier	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Other Disc/Int	Coinsurance	Deductible	FFS Withhold	Net Plan Payable	FFS/ CAP	Line Status	Expl Code
Patient Name: [redacted] Member ID#: [redacted] Claim #: [redacted] Patient Account #: [redacted] Rendering Provider Name: [redacted] NPI#: [redacted] Program: Michigan Medicaid																				
1	09/14/2010		73562	1	LT	$44.00	$17.04	$26.96	$17.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04	FFS	PAID	
2	09/14/2010		R0070	1		$174.00	$0.00	$174.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
3	09/14/2010		Q0092	1		$21.00	$0.00	$21.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
TOTAL AMOUNT:						$239.00	$17.04	$221.96	$17.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.04			
Patient Name: [redacted] Member ID#: [redacted] Claim #: [redacted] Patient Account #: [redacted] Rendering Provider Name: [redacted] NPI#: [redacted] Program: Michigan Medicaid																				
1	07/02/2010		71010	-1		-$34.00	-$14.65	-$19.35	-$14.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$14.65	FFS	PAID	
2	07/02/2010		Q0092	-1		-$21.00	$0.00	-$21.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	FFS	PAID	BAC01
3	07/02/2010		R0075	-1	UP	-$170.00	-$4.30	-$165.70	-$4.30	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$4.30	FFS	PAID	
TOTAL AMOUNT:						-$225.00	-$18.95	-$206.05	-$18.95	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	-$18.95			

Message: Reversal of Claim # is [redacted]
Member has no active enrollment on DOS

$17.04 - $18.95= ($1.91)

Voucher Summary and Check

000445-000001-000889 2081560 MB#2
Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

Temporary Return Service Requested

MOLINA HEALTHCARE

Page 1 of 3

DATE: 08/12/2010
TAX ID #:
CHECK NO.:

MEDICAL REMITTANCE ADVICE

SUMMARY OF CHECK

Billed Amount:	$265.00	Refunds:	$0.00
Contract/Allowed Amt:	$96.06	Interest:	$0.00
Disallow Amount::	$168.94	Coinsurance:	$0.00
Gross Plan Payable:	$96.06	Deductible:	$0.00
COB Amt:	$0.00	FFS Withhold:	$0.00
Co-Pay:	$0.00	Total Paid Amount:	$96.06

Total Check Amount: $96.06

Confidential Protected Health Information

This document contains confidential Protected Health Information that is protected under HIPAA and other applicable federal and state laws. This information should be safeguarded at all times and should be securely destroyed when no longer needed. This information is intended only for use by the authorized recipient. Any unauthorized use or disclosure of this information should be reported to Molina Healthcare.

To file a provider claim reconsideration, please see the reconsideration procedure on the back of this page.

Exciting COB Enhancement: Molina can now accept COB claims through the standard 837 EDI file format.

IMAGE COPY

MOLINA HEALTHCARE
Molina HealthCare of Michigan
100 West Big Beaver, Suite 600
Troy, MI 48084

USBank
Havre, MT
usbank.com
93-455/929

08/12/2010

VOID AFTER 90 DAYS

PAY Ninety-Six and 06/100 **$96.06

TO THE ORDER OF PROVIDER
PO BOX
Oak Park MI 48237