



Iowa Health Link
Iowa HHS



Hawki
Iowa HHS

Purpose: This form is for all providers disputing a claim with Molina Healthcare of Iowa and serving members in the state of Iowa. Requests must be received within 180 calendar days of date of original remittance advice. Please allow 60 calendar days to process this reconsideration request. Please submit this completed form and any supporting documentation to Molina Healthcare of Iowa.

Availity Portal: Providers are strongly encouraged to use Molina’s Provider Portal to submit claim disputes:

availability.com/molinahealthcare

Fax: The Claims Dispute Request Form can be faxed to Molina at **(855) 275-3082**. The fax must include the Claims Dispute Request Form. **Email:** lowaproviderinquiry@molinahealthcare.com

Mail: Molina Healthcare, Inc., Attn: Appeals & Grievances, PO Box 93010, Des Moines, IA 50393

Note: Please refer to the corrected claims form for submission guidelines on claims being corrected and not disputed.

**Number of faxed pages (including cover sheet): _____

Participating Not Participating

Provider’s Name: _____ NPI: _____ Federal ID: _____

Claim Number: _____ DOS: _____ Total Charges: _____
(one claim per form)

Address: _____ City/State/Zip: _____

Contact Person: _____ Phone: _____

Member’s ID #: _____ Member Name: _____ DOB: _____

Based upon the following reason(s), we are requesting reconsideration of this claim.

Category of Claim Dispute	
Provider: Please check applicable reason(s) and attach supporting documentation.	
<input type="checkbox"/> Member: Processed under incorrect member	<input type="checkbox"/> Provider: Processed under incorrect provider/tax ID number
<input type="checkbox"/> Coding/Bundling Edits: Attach supporting documentation/medical records (Documentation is required)	<input type="checkbox"/> Timely Filing: Attach claims & supporting documentation showing claim was filed to Molina in a timely manner
<input type="checkbox"/> Coordination of Benefits Information: Alternate Insurance Information/EOP Attached <input type="checkbox"/> COB – Related Adjustment Primary Insurance	<input type="checkbox"/> Payment Amount: _____
	<input type="checkbox"/> Claims Reversal Needed Reason: _____
	<input type="checkbox"/> Under/Overpayment – Explain the reasoning: _____
<input type="checkbox"/> Retrospective Medical Review: Attach reason Prior Authorization was not obtained for service performed and attach medical records.	<input type="checkbox"/> Service is not a duplicate - Explain the reasoning: _____
Comments/Other: _____ _____ _____	