# Molina Healthcare of Texas
# Appeal /Dispute Form

## Molina Healthcare of Texas Appeal/Dispute Form Instructions

This form is for Molina Healthcare of Texas Marketplace and Medicaid programs only.
If the member serviced is not enrolled in Texas, please access the state in which the member is enrolled to complete the appropriate state specific form.

Use this form to submit a written appeal for pre-authorization adverse determination or a dispute of a claim disposition

- An appeal is a request to reconsider an adverse determination due to medical necessity.
- A claim dispute is a request to reconsider an unsatisfactory claim response not related to medical necessity

If you prefer to submit an appeal or dispute electronically, log into Molina's Provider Portal: https://provider.molinahealthcare.com/

For general claim inquiries (status of a claim, question regarding a claim disposition), please use the following link: https://www.availity.com/molinahealthcare. First time users will need to register to create a login.

**Instructions for completing this form and submitting either by mail or fax:**

1. Fill out this form completely. Please describe the issue in as much detail as possible.
2. Please use **one form per denial/ payment reason**
3. This form may be used for up to nine (9) claims that have the same denial reason. Please repeat page 2 if submitting more than 2 claims with same denial reason.
4. If you have ten (10) or more claims, please email MolinaTXProviderAppealsComplaints@MolinaHealthcare.com.
5. Attach copies of any documentation to support your appeal/dispute. Please do not submit the original copies
6. Submit the completed form through one of the following:

    - Email: MolinaTXProviderAppealsComplaints@MolinaHealthcare.com
    - Fax: (877) 319-6852
    - Mail: Molina Healthcare of Texas
      Attention: Texas Appeals & Grievances
      PO Box 182273
      Chattanooga, TN 37422

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**# of pages (including CAF cover sheet)** _____ Date: _____

Provider Name: _____ Tax ID: _____ NPI: _____

Request Type: ☐ Appeal ☐ Dispute Participation Status: ☐ Contracted ☐ Non-Contracted

Contact Person: _____ Phone Number: _____

Billing Address: _____

City: _____ State: _____ Zip Code:_____

Denial/Payment Issue: _____

_____

_____

_____

_____

| | Claim Number | Member ID | Member Name | Date of Service |
|---|---|---|---|---|
| **1.** | | | | |
| **2.** | | | | |
| **3.** | | | | |
| **4.** | | | | |
| **5.** | | | | |
| **6.** | | | | |
| **7.** | | | | |
| **8.** | | | | |
| **9.** | | | | |

If you have ten (10) or more claims, please email MolinaTXProviderAppealsComplaints@MolinaHealthcare.com.