Authorization Reconsideration Request Form (Authorization Appeal or Clinical Claim Dispute)

(Form required when submitting an Authorization Appeal or a Clinical Claim Dispute request)

Number of faxed pages (including cover sheet): _____

Authorization Appeal or Clinical Claim Dispute (Authorization Reconsideration)

- A second review of a denied authorization within 30 days of the date of the denial/non-approval authorization (Pre claim) or,
- A second review of a denied authorization post-claim within 365 days of the date of service, or within 60 days of the remittance advice; whichever is later
- Changes in coding (Pre/Post Claim)
- Add on procedures (Pre/Post Claim)
- Extenuating Circumstances Post Claim (as defined in the Provider Manual). Please note in your comments if there are extenuating circumstances.

Authorization Appeal (Pre-Claim Reconsideration)

Please fax this completed form and any supporting documentation to:

- Medicaid, MMP Opt In, and MMP Opt Out
  Dental (text only, no images): (866) 292-3205

Authorization ID: _____

Clinical Claim Dispute (Post-Claim Reconsideration)

Please upload this completed form and any supporting documentation through the following methods:

- SKYGEN Dental Hub
  (https://www.dentalhub.com/molina)

Authorization ID: _____ Claim ID: _____

Member Information	
Member Name:	Date of Denial/Non-approval:
Member ID:	Service Request:
Date of Birth (DOB):	

Provider Information	
Provider Name:	Phone Number:
Facility Name:	Fax Number:
Contact Name:	Disc Password (if applicable):

Please send clinical notes and any supporting documentation. Please refer to your denial rationale for specific information required.

- Related diagnostic testing
- Treatments tried, and the effect and outcome
- Assessment and/or evaluation notes
- For Home Health, service notes and OASIS Form/485

This form is not intended to be used for Non-Clinical Claim Disputes such as administrative denials and coding edits. Please submit non-clinical claim disputes via the SKYGEN Dental Hub (https://www.dentalhub.com/molina) or to:

Molina Healthcare Provider Disputes

PO Box 649

Milwaukee, WI 53201