Provider Complaint Process

Provider Disputes and Appeals

Molina Healthcare is committed to the timely resolution of all provider complaints. Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. Provider disputes are typically disputes related to overpayment, underpayments, untimely filing, missing documents (i.e. consent forms, primary carrier explanation of benefits) and bundling issues. Provider Appeals are requests related to a denial of an authorization or medical criteria.

Providers disputing a Claim previously adjudicated must request such action within one (1) year of Molina's original remittance advice date. A written acknowledgement letter will be mailed within three (3) business days of receipt of a claim dispute or appeal. In addition a written notice of the status of your request will be mailed every 15 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within sixty (60) days of receipt of the claim dispute or appeal in accordance with 641.3155, F.S.

Molina has a dedicated staff for providers available to receive and resolve claim dispute and appeals. Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Florida via the Provider Portal. https://provider.molinahealthcare.com.
- Submit requests directly to Molina Healthcare of Florida via fax at 877-553-6504
- Submit Provider Disputes impacting more than 10 claims can be submitted via email to MFLClaimsDisputesProjects@MolinaHealthCare.Com
- Submit Provider Appeal request to MFL_ProviderAppeals@MolinaHealthcare.com Submit Provider Disputes through the Contact Center at 866-472-4585 (Monday – Friday, 8am – 7pm)
- Submit requests via mail to:

Molina Healthcare of Florida
Provider Dispute and Appeals
P.O. BOX 527450
Miami, FL 33152-7450

Please note:

Claims denied for missing or additional documentation requirements such as consent forms, invoices, Explanation of Benefits from primary carrier, or itemized bills are not considered claim disputes. In order to process your claim appropriately and promptly, these documents, along with a copy of the claim, must be received within federal and state timely filing requirements and/or your Provider Services Agreement. Please mail the documentation with the copy of the claim to:

Molina Healthcare of FL
P.O. BOX 22812
Long Beach, CA 90801

As of ***January 15, 2020***, disputes received for denial reasons stated above will be rejected.

Maximus

If the Provider Dispute/Appeal results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute/Appeal for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Maximus Federal Services State Appeals Process
50 Square Drive
Suite 120
Victor, NY 14564
Tel. (866) 763-6395
Fax (585) 425-5296

Provider Complaints Not Related to Claims

Providers with complaints not related to claims have forty-five (45) days to file a written complaint. A written acknowledgement letter will be mailed within three (3) business days of receipt of complaint. In addition a written notice of the status of your request will be mailed every 15 days and thereafter until the case is resolved. Providers will be notified of Molina's decision in writing within ninety (90) days of receipt and provided written notice of the disposition and the basis of the resolution within three (3) business days of resolution.

To file a Provider Complaint not related to claims, providers may contact Member Services at (866) 472-4585, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida, Inc.
Attention: Provider Dispute and Appeal
P.O. Box 527450
Miami, Florida 33152-7450