PASSPORT
BY MOLINA HEALTHCARE

Provider External Independent Third-Party Review Request Form

- All fields must be completed to successfully process your request.
- External independent third-party review requests with a missing or incomplete form may result in an invalid request.
- Please attach all pertinent documentation to this form that clearly states each specific issue and dispute you have with our decision and the reason you believe the decision is wrong.
- Please ensure an Internal appeal has been exhausted before submitting an external independent third-party review request. Failure to do so may result in an invalid or withdrawn request.

Submission Methods:

- Email: ReviewRequests@passporthealthplan.com
- Fax: 502-585-8334
- Mail: Passport by Molina Healthcare
- Attention: Provider Review Requests
  PO Box 36030
  Louisville, KY 40233

Note: One form per member, per claim.

Date:		Number of pages:	
Provider Information			
Provider/Group Name:		NPI:	
Contact Person:		Email:	
Phone:		Mailing Address:	
Fax:			
Check One: ☐ Provider on behalf of self ☐ Third-party billing service on behalf of provider (provide name below)			
Name of billing service:			
Member Information			
Member Name:		Member ID:	
Date of Birth:			
Claim Information			
Claim ID:		Date of Service:	
Denial Reason			
☐ Untimely Claim Filing (proof of timely filing must be included)		☐ Coding	☐ Authorization
☐ Other:		☐ Frequency	☐ Payment Dispute

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Additional Comments
Explain what you are disagreeing with and why you feel the determination is believed to be erroneous. Include and/or attach any additional information that would help the external review process.