



CLAIMS APPEAL FORM

Mail completed Claims Appeal Form to:
Superior HealthPlan
Provider Appeal Coordinator
P.O. Box 3000
Farmington, MO 63640

Provider Name	Texas Medicaid Provider Number
Claim Control Number	Date(s) of Service
Member Name	Member Number

Reason for Appeal:

- Other insurance payment (EOB; EOP must be attached)
- Incorrect payment or other (please explain below)

Comments:

Do not complete the shaded areas:

Date Received:	Due By:	Reviewed By:
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