CORRECTED CLAIM

Mail completed form to:
Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803

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

Reason for request:

☐ Other insurance payment (EOB; EOP must be attached)

☐ Incorrect payment or other (please explain below)

Comments:

Do not complete the shaded areas:

Date Received	**Date Due**	**Reviewed By**