# Provider Complaint Form

To submit a complaint, please complete the fields below and mail or fax this form to:

**Superior HealthPlan**
**ATTN: Complaint Department**
**5900 E. Ben White Blvd.**
**Austin, Texas 78741**
**Fax: 1-866-683-5369**

**Physician / Provider Name**: _____

**Name of individual completing this form**: _____

Form completed by (check one): ❑ Provider ❑ Provider Office Staff

**Phone number:** _____

**Street address**: _____

**City:** _____ **State:** _____ **Zip:** _____ **County:** _____

**E-mail address:** _____ **Fax number:** _____

**Are you a contracted provider? (check one):** ❑ Yes ❑No

**NPI Number:** _____ **TPI Number:** _____

**Provider ID Number:** _____ **Tax ID Number:** _____

**Complaint type (circle one):**

Attitude and Service Health Plan
Claims Processing – Misc.
Marketing
Plan Administration – Misc.
UR/UM – Non Covered Benefit
UR/UM – Late Notification
Other
Claims Processing – Plan Administration
Complaint Process
Physician/Provider Contracts
UR/UM – Case Management
UR/UM – Prior Authorization
UR/UM – Misc.

If "other" please specify: _____

## Complaint Details

Please describe complaint?

How can Superior fairly resolve your issue?

## Member Info

(Required if your complaint is about a specific member.)

Patient's Name: _____ Patient's Medicaid, Medicare or CHIP ID: _____

Claim Number (if applicable): _____ Date(s) of Service: _____