Corrected Claim Form

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

Provider Name	**Texas Medicaid Provider Number**
Claim Control Number (Original Claim 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**

Please Note: Handwritten Corrected Claims are not accepted by Superior HealthPlan. All corrected claims should be free of handwritten verbiage and submitted on a standard red and white UB-04 or HCFA 1500 claim form along with the original EOP. Any UB-04 or HCFA 1500 forms received that do not meet the CMS printing requirements, will be rejected back to the provider or facility upon receipt. The only acceptable claim forms are those printed in Flint OCR Red, J6983, (or exact match) ink.

When submitting corrected claims on a standard red and white form, the previous claim number should be referenced in field 64 of the UB-04 and 22 of the HCFA 1500 as outlined in the NUCC guidelines. The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 and 22 of the HCFA 1500. Omission of these data elements may cause inappropriate denials, delays in processing and payment.