Member Complaint Form

To submit, please complete the information below and mail or fax the form and any relevant documentation to:

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

Member First Name: _____ **Member Last Name:** _____

Medicaid or CHIP ID Number: _____

First Name of Person Completing Form: _____

Last Name of Person Completing Form: _____

Relationship to Member: (please circle one) Self Parent Legal Guardian Spouse

Other (please explain):_____

Phone Number: _____ **Street Address:** _____

City: _____ **State:** _____ **Zip Code:** _____

Complaint Details:

Complaint Type: (please circle one)

Access to Care	Policies/Procedures
Claims/Payment	Provider Contracting
Customer Service	Prescription Services
Electronic Visit Verification (EVV)	Quality of Care
Medical Transportation	Value-Added Services

Other: (please explain) _____

Date Incident Occurred: _____

This complaint is related to Behavioral Health or Medical Health? (please circle one)

Behavioral Health Medical Health

What is your complaint?

_____
_____
_____
_____
_____

How can Superior resolve your issue?

_____
_____
_____
_____
_____

For Administrative Use Only
Complaint No.:_____ Date Received:_____