CLAIMS APPEAL
PAYMENT RECONSIDERATION & DISPUTE FORM

Date_____

Please complete the following form to help expedite the review of your claims appeal.
***Is this a**

- ☐ **Request for Reconsideration**: you disagree with the original claim outcome (payment amount, denial reason, etc.) Please check if this is the first time you are asking for a review of the claim.
- ☐ **Claim Dispute**: you disagree with the outcome of the Request for Reconsideration.

Provider Name*	**Provider Tax ID***
Provider NPI*	**Date of last Explanation of Payment**
Superior Claim Number*	**Dates of Service***
Member Name	**Member ID**

*** Indicates a required field**

Reason for the appeal (please check all that apply):

- ☐ Claim was denied for no authorization, but authorization number _____was obtained
- ☐ Claim was denied for no authorization, but no authorization is required for this service
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information)
- ☐ Claim was denied for **incomplete or missing sterilization form**, but one was submitted with claim (attach completed form)
- ☐ Claim was not paid per the terms of my contract with Superior HealthPlan (attach relevant reimbursement section)
- ☐ Claim was denied "**Past Timely Filing**" (attach proof of timely filing)
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information)
- ☐ Other: Please explain

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Please ensure sufficient detail is provided to assist us in the review of your reconsideration or dispute.

Mail completed forms and all attachments to
Superior HealthPlan
Claims Reconsiderations & Disputes Department
PO BOX 3000
Farmington, Missouri 63640-3800

Contact name & number of person requesting the appeal _____