# Request for Claim Status

Phone: 1-877-391-5921
Fax: 1-866-461-9462

superior healthplan

Date* __ __ / __ __ / __ __ __ __

Contact First Name

Contact Number ___ - ___ - ____ EXT.

Provider Tax ID

Fax Number ___ - ___ - ____

* Required Information. Please do not write in the grey areas.

| Provider Name* | Member DOB/Last 4 of SSN | Member ID Number * | Date of Service * | Billed Amount | For Superior HealthPlan Use Only | | |
|---|---|---|---|---|---|---|---|
| | | | | | Amount Paid | Check # | Status |
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**Please allow five business days for Superior HealthPlan to review and return requests for claim status.**

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