



**superior
healthplan**
Advantage

CORRECTED CLAIM

Mail completed form to:
Superior HealthPlan Advantage
Corrections, Reconsiderations, or
Appeals P.O. Box 4000
Farmington, MO 63640-4400

Provider Name	Medicare Number and/or NPI Number
Claim Control 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
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