SUPERIOR HEALTH PLAN

MEDICAL NECESSITY APPEAL FORM

__ I want to file an appeal

You can call 1-800-218-7453 to file your appeal orally, then **mail or fax this completed form** to:

Superior HealthPlan
Attn: Appeals Coordinator
5900 E. Ben White Blvd.,
Austin, TX 78741
Fax: 1-866-918-2266

Member name _____

Medicaid ID number _____

Name of person submitting the appeal _____

Relationship to member: __ Parent Legal guardian/Foster Parent Family member Friend
Lawyer Spouse Other, _____

Contact phone number (_____)_____

What Service Was Denied_____

You can send us more information on your case. Use the space below if you want to send us more information. You can add more sheets if you need to. Please Include a copy of the denial letter.

Signature of person appealing _____ Date _____