DO NOT USE THIS FORM FOR A RECONSIDERATION REQUEST.
USE THE "RECONSIDERATION REQUEST FORM".

Claim Appeal Form

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the appeal. Any appeal request received with an incomplete form and/or missing documentation cannot be reviewed and will be returned to you for completion.

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

***Required fields**

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

Reason for the appeal:

- ☐ 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.
- ☐ Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with Superior HealthPlan (attach relevant reimbursement section).
- ☐ Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
  - o *Note: If the past timely filing deadline denial falls on a weekend or holiday, the provider may request a reconsideration (see Reconsideration Request Form, Attachment N within Provider Manual).*
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information)
- ☐ Claim denied based on Superior HealthPlan's payment policy (attach medical records to support services provided).
  - o *Note: Payment policies can be found at https://www.superiorhealthplan.com/providers/resources/clinical-payment-policies.html*
- ☐ Other. Please explain (and provide supporting documentation):

_____

_____

_____

Please ensure sufficient detail is provided to assist us in the review of your appeal.

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: _____