Reconsideration Request Form

Please Check Below - Attached is the requested information/documentation:

- Sterilization consent form
- Primary insurance EOP
- Invoice
- Itemized bill (inpatient hospital claims or as requested)
- Unlisted procedure code documentation
- Medical records related to a claim denial (NOT related to a medical necessity appeal)

Note: No form is required for the submission of corrected claims. Please refer to the Corrected Claim Process section of the Superior HealthPlan Provider Manual.

OR

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.

- Claim was denied for no authorization, but authorization number _____________________ was obtained.
- Claim was denied due to lack of Texas Provider Medicaid enrollment. The TPI is: ____________________
- Claim was not paid per the terms of my contract with Superior HealthPlan. Please explain and advise of your payment expectation/amount:

_______________________________________________________________________________________
_______________________________________________________________________________________

- Other. Please explain.

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

☐ Check box if this Reconsideration Request is for multiple claims. Please attach a separate list if more than one claim number and/or member ID is related to this reconsideration request.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Tax ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider NPI</td>
<td>Date of last Explanation of Payment</td>
</tr>
<tr>
<td>Superior Claim Number*</td>
<td>Dates of Service*</td>
</tr>
<tr>
<td>Member Name*</td>
<td>Member ID*</td>
</tr>
</tbody>
</table>

*Required fields

Mail completed forms and all attachments to:
Superior HealthPlan
Claims Reconsiderations
PO BOX 3003
Farmington, Missouri 63640-3803

Contact name & number of person requesting the appeal: ____________________________________________

SuperiorHealthPlan.com
SHP_20195192B