



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.

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*

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: _____