Provider Complaint Form

To submit, please complete the information below and mail or fax the form and any relevant documentation to:
Superior HealthPlan
ATTN: Complaint Department - 5900 E. Ben White Blvd., Austin, Texas 78741
Fax: 1-866-683-5369

Please Note: For claims-related complaints only: Claims detail and / or examples are required for a full review of the complaint to be completed.

Provider First Name: _____ **Provider Last Name:** _____

Practice/Clinic/Facility Name: _____

Form Completed By: (please circle one) Provider Provider Office Staff

E-mail Address: _____

Practice Phone Number: _____ **Fax Number:** _____

Practice Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Are you a contracted provider? (please circle one) Yes No

NPI Number:_____ Tax ID Number: _____

Complaint Details:

Complaint Type: (please circle one)

- Access to Care
- Claims/Payment
- Customer Service
- Electronic Visit Verification (EVV)
- Medical Transportation
- Policies/Procedures
- Provider Contracting
- Prescription Services
- Quality of Care
- Value-Added Services
- Other: (please explain): _____

Date Incident Occurred: _____

This complaint is related to Behavioral Health or Medical Health? (please circle one)

Behavioral Health Medical Health

What is your complaint?

_____
_____
_____
_____
_____

How can Superior resolve your issue?

_____
_____
_____
_____
_____

Member Information:

(Required if your complaint is about a specific member)

Member First and Last Name:_____ **Member Medicaid or CHIP ID:** _____

Claim Number (if applicable): _____ **Date(s) of Service:** _____