Reconsideration Request Form

*Please Note: DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE **CLAIM APPEAL FORM**.*

The requested information/documentation is being submitted for reconsideration (select all that apply):

- ☐ 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 STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual (PDF)**.

OR

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate *Reconsideration Request Form* for each reason/explanation code as listed on your Explanation of Payment (EOP).

- ☐ Claim was denied for no authorization, but authorization number _____was obtained.
- ☐ Claim was denied due to lack of Provider Medicaid or CHIP enrollment through Texas Health and Human Services Commission.
- ☐ 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 include 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 EOP:
Superior Claim Number:*	Dates of Service:*
Member Name:*	Member ID Number:*

Required fields

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

Contact name of the person requesting the reconsideration: _____

Phone number of the person requesting the reconsideration: _____