



Superior's Secure Provider Portal

Provider Training

Introductions and Agenda



- Secure Provider Portal Highlights
- Secure Provider Portal Registration
- Eligibility
- Patient List
- Authorizations
- Claims
- Secure Messages
- User Management
- Provider/Practitioner
Info Management
- Questions and Answers



Secure Provider Portal Highlights

Secure Provider Portal Highlights



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- View multiple Tax Identification Numbers (TINs):
 - 1 point of entry allows for quick and easy access to Superior member information for multiple TINs/practices.
- Access daily patient lists from 1 screen:
 - 1 concise view allows Primary Care Providers (PCPs) to scan patient lists for details, such as Superior member eligibility and care gaps.
- Manage batch claims for free:
 - Submit and manage claims, including batch, and view detailed Electronic Funds Transfer (EFT) payment history.

Welcome

Add a TIN to My ACCOUNT >

Manage Accounts >

Reports >

Recent Activity

Date	Activity
------	----------

Health Passport

Launch Health Passport >

[Health Passport online training](#)

[STAR Health Trainings & Behavioral Health Resources](#)

STAR Health Webinar recordings accessible on this website are for the use and training of the Department of Family and Protective Services (DFPS) staff only.

Resources

[Practice Guidelines](#)

[PaySpan](#)

Secure Provider Portal Highlights



- Simplify prior authorization process:

- Submit prior authorization requests using the “Smart Sheets” feature, with prompts for required clinical information.

Utilize additional features to streamline office operations:

- View patient demographics and history.
- Use the secure messaging feature to communicate with Superior.
- Update provider demographics.

A screenshot of the Superior Healthplan Secure Provider Portal interface. The page has a light blue header with the "Welcome" title. Below the header, there are three buttons: "Add a TIN to My ACCOUNT", "Manage Accounts", and "Reports", each with a right-pointing arrow. Underneath these buttons is a section titled "Recent Activity" with a table that has two columns: "Date" and "Activity". Below the "Recent Activity" section is a "Health Passport" section with a button labeled "Launch Health Passport" and a right-pointing arrow. Under the "Health Passport" button, there are two links: "Health Passport online training" and "STAR Health Trainings & Behavioral Health Resources". Below the "STAR Health Trainings & Behavioral Health Resources" link, there is a paragraph of text: "STAR Health Webinar recordings accessible on this website are for the use and training of the Department of Family and Protective Services (DFPS) staff only." At the bottom of the page is a "Resources" section with two links: "Practice Guidelines" and "Pay Span".



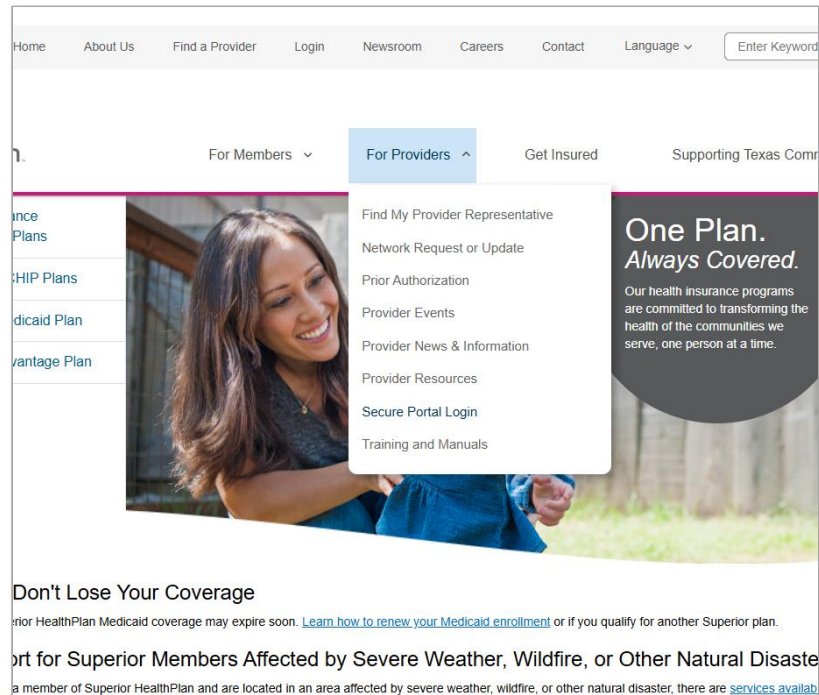
Secure Provider Portal Registration

Registration



- Navigate to SuperiorHealthPlan.com and hover over **For Providers**. Click on **Secure Portal Login** to register.

Please note: A user account is required to access Superior's Secure Provider Portal.



Registration



Click on the pink button that reads **Providers contracted for STAR...** to proceed to the Log In screen.

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For Members ▾

For Providers ▾

Get Insured

Supporting Texas Communities ▾

For Providers

Find My Provider Representative

Network Request or Update ▾

Prior Authorization ▾

Provider Events ▾

Provider News & Information

Provider Resources ▾

Secure Portal Login

Training and Manuals ▾

Secure Portal Login

Superior HealthPlan is committed to providing our participating providers with the best tools possible to support their administrative needs. We encourage our participating providers to take advantage of our easy-to-use secure web portal for fast resolution of routine needs.

File claims electronically and directly to Superior HealthPlan with no clearing house fees. Our secure portal allows you to submit your claims quickly and easily online as well as request copies of your Explanation of Payment (EOP). Our electronic transactions capabilities will speed up the processing and payment of your claims.

The web portal can be used to:

- Verify member eligibility.
- Submit claims and check their status.
- Submit and confirm authorizations.
- View detailed patient lists.
- Update provider demographic information.*

For more information please review the [Secure Provider Portal Booklet \(PDF\)](#).

Providers contracted for STAR, STAR+PLUS, STAR Health, STAR Kids, CHIP, Wellcare By Allwell, STAR+PLUS Medicare-Medicaid Plan (MMP) and Ambetter from Superior HealthPlan can login/register here. [↗](#)

Secure Web Portal Support

For support while using the web portal, please call [1-866-895-8443](tel:1-866-895-8443) or email TX_WebApplications@superiorhealthplan.com

*In addition to updating information with Superior, providers must also update their demographics with Texas Medicaid & Healthcare Partnership (TMHP). To update demographic information in the TMHP Provider Information Management System (PIMS), please visit the [TMHP Medicaid Providers homepage](#) [↗](#). For more information on using the PIMS, please reference the [TMHP PIMS User Guide \(PDF\)](#) [↗](#).

Registration



Select **Create New Account** to begin registering.

Log In

Email Address *

CONTINUE

[Create New Account](#)

single password  reliable security

EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#)

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Registration



Enter your Email Address and click **Continue** to begin registering.

Create Your Account

Enter Your Email Address

Let's get started – creating an account is quick and easy.

Email Address *

Continue

Cancel

single password

A circular logo with a stylized 'K' inside.

reliable security

EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#)

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Registration



Complete the registration form and click **Continue**.


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Create Your Account
Tell Us About You
Enter your name and language preference.
Email Address *

First Name *

Last Name *

Language Preference *

Select a Language ▼

Continue

Cancel

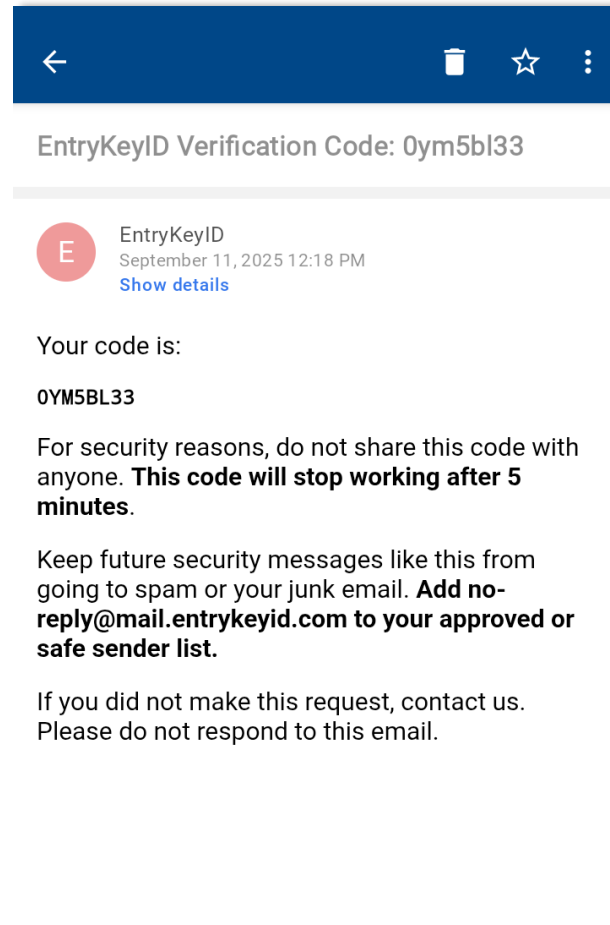
Already have an account? [Log In](#)

By creating an account, you are agreeing to the [terms and conditions](#) of the website

Registration



A Verification Code email will automatically be sent to the email address provided during registration.



Registration



Enter the Verification Code
you received in your email and
click **Continue**.


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Create Your Account
Verify Your Email Address
Please do not close this window.
We sent a code to your email. Don't see it? Check your spam or junk email.
Enter the code below. This code will stop working after 10 minutes.
Verification Code *

Continue

single password  reliable security

EntryKeyID

[Help](#) [Privacy Policy](#) [Terms of Use](#)

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Registration



Enter a Password and confirm it and click **Set Password**.

Create Your Account

Set Your Password

Enter a password and confirm it.

Password *

Password must meet criteria below.

Confirm Password *

Confirming your password is required.

A strong password must:

- ☐ Have a minimum of 12 characters
- ☐ Include all of the following:
 - ☐ One uppercase letter
 - ☐ One lowercase letter
 - ☐ One number
 - ☐ One special character (Example: &, \$, !, *)

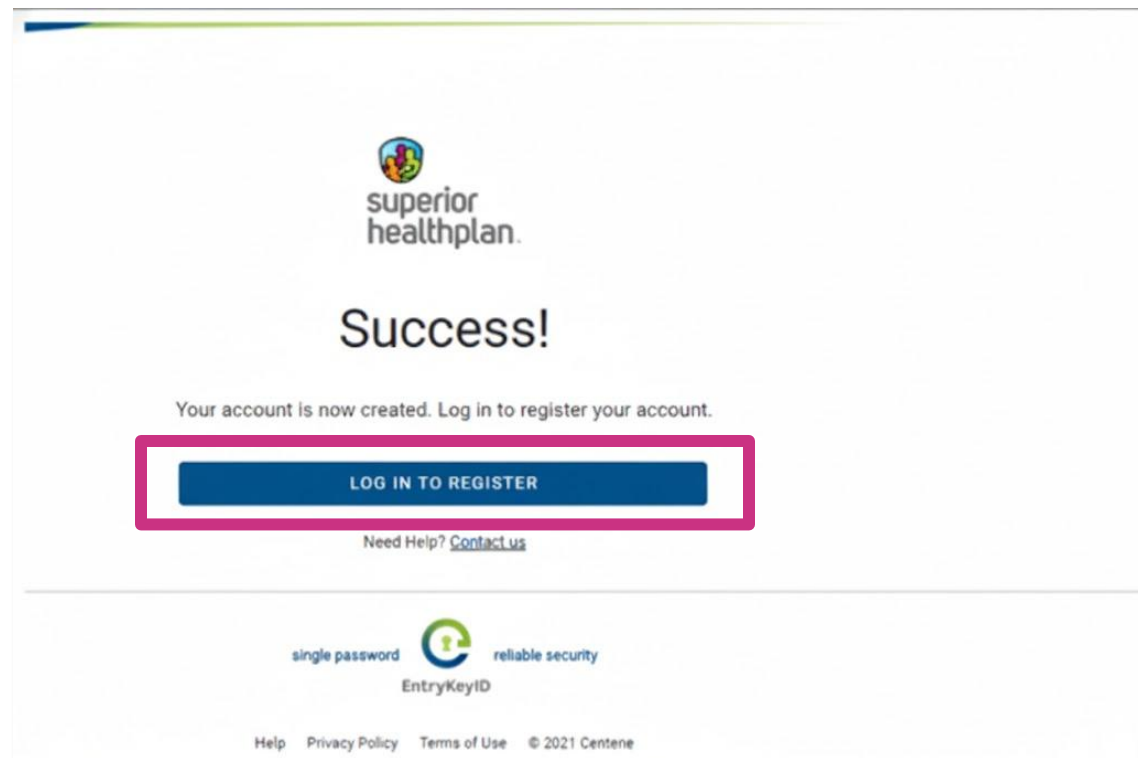
Set Password

Cancel

Registration



Log In To Register to complete registration.



Registration

Enter information and click **Submit**.



superior healthplan. wellcare By allwell.™ ambetter.™ from Superior HealthPlan wellcare By superior healthplan.

Provider Registration

Enter your account details to complete your registration

Select your registration type:

☒ Medical/Behavioral Provider

☐ Dental/Vision Provider

☐ Foster Care Member, Medical Consenter, Foster Parent, DFPS Staff, RTC/CPA Staff, CASA Staff, SSOC

Tax ID

?

Business Phone

Fax Number

SUBMIT

CANCEL

Registration



Registration is Complete!

A screenshot of a web form titled "Provider Registration" with a dark header bar containing logos for "superior healthplan.", "wellcare By allwell.", "ambetter.™ from Superior HealthPlan", and "wellcare By superior healthplan.". The form has a light gray background and contains the following elements:

- Title: "Provider Registration"
- Instruction: "Enter your account details to complete your registration"
- Label: "Select your registration type:"
- Radio button: "Medical/Behavioral Provider" (selected)
- Modal box (highlighted with a red border):
 - Title: "Registration Complete" (with a close 'X' button)
 - Text: "Thank you for completing your registration!"
 - Text: "A Superior HealthPlan provider services specialist will be sending you an email when your profile has been activated. Please allow up to two business days for processing."
 - Text: "If you do not receive an email within 2 business days, please log in and contact us using secure messaging or call 866-895-8443 for additional assistance."
- Label: "Fax Number" (partially obscured by the modal)
- Input field: A text box for the fax number.
- Buttons: "SUBMIT" (black) and "CANCEL" (gray).

Provider Portal Dashboard



- Once logged into the web portal account, you will see the Welcome Screen

The screenshot displays the Superior HealthPlan Provider Portal Dashboard. At the top, a dark blue navigation bar contains the Superior HealthPlan logo and several menu items: Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this bar, a section for "Viewing Dashboard For:" includes a dropdown for "TIN" (currently empty), a dropdown for "Plan Type" (set to "Medicaid / CHIP"), and a green "GO" button. A pink alert box on the left states: "ATTENTION PROVIDERS: Ensure your provider directory data is accurate and help members find the care they need. Take action now to update your information at [SuperiorHealthPlan.com/UpdateDemographics](\"http://SuperiorHealthPlan.com/UpdateDemographics\")." The main content area is titled "Home: Superior HealthPlan" and features a "Quick Eligibility Check" section with input fields for "Member ID or Last Name" (containing "123456789 or Smith") and "Birthdate (mm/dd/yyyy)" (empty), followed by a green "Check Eligibility" button. Below this is a "Superior Claim System Enhancement" box with text about claim processing updates and a "Please note" section. The right sidebar contains a "Welcome" section with a list of links: "Add a TIN to My ACCOUNT", "Manage Accounts", "Reports", "Patient Analytics", "Provider Analytics", and "Care and Risk Gaps - Daily View", each with a right-pointing arrow. Below this is a "Recent Activity" section with columns for "Date" and "Activity". The bottom of the sidebar has a "Resources" section.

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Eligibility Patients Authorizations Claims Messaging Help

Viewing Dashboard For : TIN [dropdown] Plan Type [dropdown: Medicaid / CHIP] [GO]

ATTENTION PROVIDERS: Ensure your provider directory data is accurate and help members find the care they need.
Take action now to update your information at SuperiorHealthPlan.com/UpdateDemographics.

Home: Superior HealthPlan

Quick Eligibility Check

Member ID or Last Name Birthdate (mm/dd/yyyy)

123456789 or Smith [input] [input] [Check Eligibility]

Superior Claim System Enhancement

Enhancements to Superior's claims system have recently been made to help increase the speed of claims processing. As a result, providers may now see some claim numbers with an alpha character in the 8th position. The following is an example of the updated claim numbers: Q045TXEA0001.

Please note: This update does not affect the way claims are submitted and processed. For any questions on this change, please contact your local Superior Account Manager.

Recent Claims

Welcome

- Add a TIN to My ACCOUNT >
- Manage Accounts >
- Reports >
- Patient Analytics >
- Provider Analytics >
- Care and Risk Gaps - Daily View >

Recent Activity

Date	Activity
------	----------

Resources



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Eligibility

Secure Portal Eligibility Tab



- The **Eligibility** tab offers an Eligibility Check tool designed to quickly check the status of any member.

The screenshot shows the "Eligibility" tab selected in the top navigation bar. Below the navigation bar, there is a section for "Viewing Eligibility For:" with a "TIN" dropdown menu and a "Plan Type" dropdown menu set to "Medicaid / CHIP". A green "GO" button is next to the "Plan Type" dropdown. Below this is the "Eligibility Check" section, which contains three input fields: "Date of Service" (with the value "09/19/2025" and a "(mm/dd/yyyy)" label), "Member ID or Last Name" (with the value "123456789 or Smith" and a "(mm/dd/yyyy)" label), and "Date Of Birth" (with a "(mm/dd/yyyy)" label). To the right of these fields are two buttons: a green "Check Eligibility" button and a "Print" button. Below the input fields is a table with the following headers: "ELIGIBLE", "DATE OF SERVICE", "PATIENT NAME", "DATE CHECKED", "RECENT ADT", "CARE GAPS", and "LOG ER VISIT". At the bottom of the page, there are links for "Terms and Conditions" and "Privacy Policy", both labeled "(new tab)", and a copyright notice: "Copyright © 2025, Centene Corporation".

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Eligibility Patients Authorizations Claims Messaging Help

Viewing Eligibility For : TIN [dropdown] Plan Type [dropdown] Medicaid / CHIP [dropdown] GO

Eligibility Check

Date of Service 09/19/2025 (mm/dd/yyyy)

Member ID or Last Name 123456789 or Smith (mm/dd/yyyy)

Date Of Birth [dropdown] (mm/dd/yyyy)

Check Eligibility Print

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	RECENT ADT	CARE GAPS	LOG ER VISIT
----------	-----------------	--------------	--------------	------------	-----------	--------------

[Terms and Conditions](#) (new tab) [Privacy Policy](#) (new tab) Copyright © 2025, Centene Corporation

Eligibility Search



- Eligibility status is indicated by a green thumbs-up for eligible and an orange thumbs-down for ineligible.
- Details for any member can be viewed by clicking on the **Patient Name**.
- **Care Gaps** can also be seen within the search results.
- By clicking **ER Visit**, an ER visit can be added.

The screenshot shows the Superior Healthplan Eligibility Search interface. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows users to filter by TIN and Plan Type (Medicaid / CHIP), with a green GO button. The main section is titled "Eligibility Check" and contains input fields for Date of Service (09/19/2025), Member ID or Last Name (123456789 or Smith), and Date Of Birth. A green "Check Eligibility" button and a "Print" button are also present. Below the search fields is a table with columns: ELIGIBLE, DATE OF SERVICE, PATIENT NAME, DATE CHECKED, RECENT ADT, CARE GAPS, and LOG ER VISIT. The table has two rows: one with a thumbs-down icon and "Not Found" status, and another with a thumbs-up icon and "Eligible" status. The "PATIENT NAME" column in the second row is highlighted with a red box, showing "Mf" and "Mf" with a ">View details" link. The "CARE GAPS" column in the second row is also highlighted with a red box. The "LOG ER VISIT" column in the second row has a button labeled "ER Visit?" which is highlighted with a red box. At the bottom, there are links for "Terms and Conditions" and "Privacy Policy", and a copyright notice for Centene Corporation.

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	RECENT ADT	CARE GAPS	LOG ER VISIT
Not Found	09/19/2025	No members found.	09/19/2025			Remove
Eligible	09/19/2025	Mf Mf >View details	09/19/2025	NO		ER Visit? Remove

Eligibility Search



- Patient Information and PCP Information are displayed in the member's **Overview**.

A screenshot of the Superior Healthplan web application. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section allows users to filter by "Viewing Eligibility For" (TIN) and "Plan Type" (Medicaid / CHIP), with a "GO" button. The main content area is titled "Overview" and features a sidebar with a list of menu items: Overview, Cost Sharing, Assessments, Health Record, ADT, Care Plan / IMP, Authorizations, Referrals, Coordination of Benefits, Claims, and Document Resource Center. The "Overview" item is highlighted with a red box. The main content area displays a green banner stating "This patient is eligible as of today, Jul 29, 2025" with a thumbs-up icon. Below this, there are sections for "Patient Information" and "PCP Information". The "Patient Information" section includes fields for Name, Gender, Birthdate, Age, Member #, and Address. The "PCP Information" section includes fields for Name, Address, Practice Type, and Phone Number. At the bottom, there is a section for "Eligibility History" with a note that future effective dates may be subject to change based on certain factors. A "Print Eligibility Overview" link is also present.

Eligibility Search

- Overview also includes **Eligibility History**, **PCP History** and **EPSDT** for the respective member.
- **Care Gaps** and **Service Coordinator** information will only display when applicable.



Member # [Redacted]
Address [Redacted]
Redetermination Date [Redacted]

[View PCP History](#)

Name	Start Date	End Date
[Redacted]		

[Eligibility History](#)
Future effective dates may be subject to change based on confirmed eligibility files from HHSC or CMS.

Start Date	End Date	Region	Product Name
[Redacted]			

[more](#)

[Service Coordinator](#)

Name Service Coordination Outreach
Phone # 1-877-277-9772

[EPSDT](#)

EPSDT	Date Completed
[Redacted]	

[Care Gaps](#)

No flu vaccine in past 12 months.

Risk Category Alerts: COPD/Asthma

Member has had 3 or more emergency room visits in past 90 days.

Member has had 1 or more emergency room visits in the past 30 days.

Care Gap Alert

Categories and Descriptions



- Adult Preventive
 - No mammogram in most recent 12 months.
 - No Chlamydia test in past 12 months in patient 16 - 25 years of age.
 - No PAP in past 12 months.
- Diabetes
 - DM - Not seen in past 6 months.
 - DM - No retinal eye exam in past 12 months.
 - DM - No HbA1C screening in past 12 months.
- Cardiac
 - CAD - Not seen in past 12 months.
 - HTN - Not seen in past 12 months.

Care Gap Alert

Categories and Descriptions



- Flu Vaccine
 - No flu vaccine in past 12 months.
- Child Preventive
 - Immunizations not current for age.
- Texas Health Steps
 - Non-compliant for well child visits.
- Emergency Room Visits
 - Any ER visits in past 12 months.

Eligibility Search



- Overview also includes **Allergies** and **View Clinical Information** option for the respective member.

[Allergies](#)

None On File

[View Clinical Information](#)

Three Most Recent ER Visits

Top 5 Most Occurring Diagnosis

Three Most Recent Inpatient Admissions

Recent Pharmacy Activity

Three Most Recent Office Visits



Eligibility Search



- **Cost Sharing** information is displayed for those CHIP members who have co-pays.
- This member has no co-pay is displayed when a member does not have cost sharing.

A screenshot of the Superior Healthplan web application. The top navigation bar includes the Superior Healthplan logo and links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar shows "Viewing Eligibility For: TIN" and "Plan Type: Medicaid / CHIP" with a green "GO" button. The main content area has a sidebar on the left with a "Back to Eligibility Check" button and a list of menu items: Overview, Cost Sharing (highlighted with a red box), Assessments, Health Record, ADT, Care Plan / IMP, Authorizations, Referrals, Coordination of Benefits, Claims, and Document Resource Center. The main content area displays the text "This member has no co-pay" and a link to "Print Cost Sharing". The footer contains links for "Terms and Conditions" and "Privacy Policy" (both opening in new tabs) and a copyright notice for Centene Corporation.

Eligibility Search



- Click **Start an Assessment** to begin your assessment.
- **SSFB Provider NOP (Notification of Pregnancy)** assessments can be completed online.

The screenshot displays the 'Assessments' page in the Superior Healthplan system. On the left, a sidebar menu lists various services, with 'Assessments' highlighted. The main content area shows a 'Start an Assessment' button, which is circled in red. Below this, a search bar and a table of assessment types are visible. The table lists several assessment types, each with a 'Start Assessment' link. The 'SSFB Provider NOP' assessment type is highlighted with a red box, indicating it is the one to be selected for completion.

Assessment	Start the Assessment
Non-Medical Needs Screening	Start Assessment
Pediatric Non Complex Assessment	Start Assessment
Pediatric Mini Screener	Start Assessment
DOH Mini Screener	Start Assessment
SDOH Closed Loop Assessment	Start Assessment
SSFB Provider NOP	Start Assessment

Eligibility Search



- **Health Record** will allow you to view the respective member's visits, medications, immunizations, labs and allergies if there are any listed.

The screenshot displays the Superior Healthplan web interface. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows users to view eligibility for a specific TIN and Plan Type (Medicaid / CHIP), with a green GO button. The main content area is titled "Health Record" and includes a sidebar with various menu items. The "Health Record" menu item is highlighted with a red box. The main content area shows tabs for Visits, Medications, Immunizations, Labs, and Allergies. A yellow banner indicates that the information is based on submitted claims. Below this, a table lists health record entries with columns for Primary Diagnosis, Date, Visit Type, Claim Type, and Facility/Provider. The table contains several rows of data, including entries for "Other Pervasive Developmental D/O", "Duchenne Or Becker Muscular Dystrophy", and "Epigastric Pain".

Primary Diagnosis	Date	Visit Type	Claim Type	Facility/Provider
Other Pervasive Developmental D/O				
Other Pervasive Developmental D/O				
Duchenne Or Becker Muscular Dystrophy				
Epigastric Pain				
Other Pervasive Developmental D/O				
Mixed Incontinence				
Other Pervasive Developmental D/O				
Other Pervasive Developmental D/O				

Eligibility Search



- **ADT (Admission Discharge Transfer)** will allow you to view the respective member's admission, discharge or transfer for the past 12 months.

A screenshot of the Superior Healthplan web application. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows users to filter by TIN and Plan Type (Medicaid / CHIP), with a green GO button. The main content area is titled "ADT (Admission Discharge Transfer)" and includes a sub-header "Admission Discharge & Transfer Notifications display for the last 12 months". A table with four columns (DATE & TIME, TYPE, FACILITY NAME, DISCHARGE DISPOSITION) is shown, but it is empty. On the left side, a sidebar menu lists various services: Overview, Cost Sharing, Assessments, Health Record, ADT (highlighted with a red box), Authorizations, Referrals, Coordination of Benefits, Claims, and Document Resource Center. The footer contains links for Terms and Conditions, Privacy Policy, and a copyright notice for Centene Corporation.

Eligibility Search



- Member/caregiver is called and offered Case Management or Care Coordination.
- If they accept, the Case Manager or Social Worker/Service Coordinator develops a plan of care with the member/caregiver.
- Goals are identified and a care plan or Integrated Member Plan (IMP) is formulated and seen here in the **Care Plan/IMP** module.

A screenshot of the Superior Healthplan web application. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows users to view eligibility by TIN (with a dropdown menu) and Plan Type (set to Medicaid / CHIP), with a green GO button. The main content area has a sidebar on the left with a list of modules: Overview, Cost Sharing, Assessments, Health Record, Care Plan / IMP (highlighted with a red box), Authorizations, Referrals, Coordination of Benefits, Claims, and Document Resource Center. The main panel shows the "Integrated Member Plan (IMP)" section, which includes tabs for "Integrated Member Plan" and "Care Plans". A yellow message box states "No Care Plans available for member."

Eligibility Search



- The previous 12 months of **Authorizations** display for each member.
- New authorizations can be quickly generated for a member by clicking **Create**.

A screenshot of the Superior Healthplan web application. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section shows "Viewing Eligibility For:" with a dropdown for TIN and a dropdown for Plan Type (currently set to "Medicaid / CHIP"), followed by a "GO" button. The main content area is titled "Authorizations" and includes a sidebar with navigation links: Overview, Cost Sharing, Assessments, Health Record, ADT, Care Plan / IMP, Authorizations (highlighted with a red box), Referrals, Coordination of Benefits, Claims, and Document Resource Center. The main area contains a "Create" button (highlighted with a red box), a search bar with a "SEARCH" button, and a "DATE RANGE FILTER" section. The date range is set to "09/22/2015 - 09/22/2025". Below this, a table displays authorization data.

	Service Type	Authorization No.	Start Date	End Date	Diagnosis Code
▼	Therapy-Treatment		07/08/2025	01/02/2026	F84.0,F84.8
▼	Therapy-Treatment		06/04/2025	11/30/2025	G71.01

Eligibility Search



- Providers can now refer members to Case Management on the portal by clicking **Referrals**.

A screenshot of the Superior Healthplan portal interface. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section shows "Viewing Eligibility For: TIN" and "Plan Type" with dropdown menus and a "GO" button. The main content area is divided into a left sidebar and a right main panel. The sidebar contains a list of menu items: Overview, Cost Sharing, Assessments, Health Record, ADT, Care Plan / IMP, Referrals (highlighted with a red box), Coordination of Benefits, Claims, and Document Resource Center. The main panel is titled "Referrals" and shows a date of "09/22/2025 10:39 AM". It contains a form with fields for "Referral Type" (a dropdown menu), "First Name", "Last Name", "Phone Number" (with a format guide), "Extension", and "Phone Type" (radio buttons for Work, Cell, Home). There is also a text area for "Additional Comments" with a character count of "1500 characters remaining". A "Submit" button is at the bottom of the form.

Eligibility Search



- **Coordination of Benefits** information will display for a member when applicable.

A screenshot of the Superior Healthplan web application. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows users to filter by TIN and Plan Type (currently set to Medicaid / CHIP), with a green GO button. A sidebar on the left contains a list of menu items: Overview, Cost Sharing, Assessments, Health Record, ADT, Care Plan / IMP, Authorizations, Referrals, Coordination of Benefits (highlighted with a red box), Claims, and Document Resource Center. The main content area is titled "Coordination of Benefits" and displays a message: "We do not have any COB information."

Eligibility Search



- The **Claims** display for each member for the past month. They are now searchable by year and by month for up to 30 days at a time.
- New claims can be quickly created for a member by clicking **Create a New Claim**.

A screenshot of the Superior Healthplan web application. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for "Viewing Eligibility For:" shows a TIN dropdown and a Plan Type dropdown set to "Medicaid / CHIP", with a green "GO" button. The main content area has a left sidebar with a menu: Overview, Cost Sharing, Assessments, Health Record, ADT, Care Plan / IMP, Authorizations, Referrals, Coordination of Benefits, Claims (highlighted with a red box), and Document Resource Center. The main panel is titled "Claims: Recent" and contains a message: "The last one month of claims for this member are displayed below. To view more claims for this member, visit the Claims page." Below this is a filter section with "Show claims for" set to "2025" and "September", and a "GO" button. A "View most recent month" link is also present. A green "Create a New Claim" button is highlighted with a red box. At the bottom, a light blue message box states: "There are no recent claims for this patient."



Patient List

Patient List

- Click on **Patients** to display the patient list. These are members assigned to a provider under this TIN as their PCP.



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Eligibility Patients Authorizations Claims Messaging Help

Viewing Patients For: TIN Plan Type

Patient List as of (mm/dd/yyyy)

Only first 1500 records will be displayed. Use filters to view specific records.

This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

Eligible	Preferred Language ↑	HPR	Member Name ↑	Member ID / CHIP ID ↑	Member # ↑	Date of Birth ↑	Phone Number ↑	ALERTS	Texas Health Steps Last Visit Date ↑	Redetermination Date ↑
Eligible	English								01/16/2024	Not Available
Eligible	English							NM	None On File	Not Available
Eligible	English							CG DM	11/21/2023	Not Available

Patient List

- **Download** the Patient List to Excel and save all of the relevant member and provider information.



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Eligibility Patients Authorizations Claims Messaging Help

Viewing Patients For : TIN Plan Type Medicaid / CHIP

Patient List as of (mm/dd/yyyy) 09/23/2025

Only first 1500 records will be displayed. Use filters to view specific records.

This is only a list of your patients, please check eligibility to confirm the effective date and benefits for this member.

Eligible	Preferred Language ↑	HPR	Member Name ↑	Member ID / CHIP ID ↑	Member # ↑	Date of Birth ↑	Phone Number ↑	ALERTS	Texas Health Steps Last Visit Date ↑	Redetermination Date ↑
Eligible	English								01/16/2024	Not Available
Eligible	English							NM	None On File	Not Available
Eligible	English							CG DM	11/21/2023	Not Available



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Authorizations

Member Overview



- The **Authorizations** tab offers a summary of all activity for the previous 90 days.

A screenshot of the Superior Healthplan website's "Authorizations" page. The page has a dark blue header with the Superior Healthplan logo on the left and navigation tabs: "Eligibility", "Patients", "Authorizations" (highlighted with a pink box), "Claims", "Messaging", and "Help". Below the header, there's a section for "Viewing Authorizations For:" with a "TIN" dropdown menu, a "Plan Type" dropdown menu set to "Medicaid / CHIP", and a green "GO" button. To the right is an orange "Create Authorization" button. Below this is a light blue bar with "Authorizations" as the main title, and sub-tabs for "Processed", "Errors", and "Disclaimer". A "Filter" button is on the right. The main content area has a message: "Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours." Below this is a light blue box stating "There are no authorizations to show." At the bottom, there are links for "Terms and Conditions" and "Privacy Policy", both opening in new tabs, and a copyright notice for Centene Corporation, 2025.

Authorizations



- Select **Create Authorization** from the **Authorizations** tab.

A screenshot of the Superior Healthplan web application interface. The top navigation bar includes tabs for Eligibility, Patients, Authorizations (highlighted with a red box), Claims, Messaging, and Help. Below the navigation bar, there are filters for "Viewing Authorizations For : TIN" and "Plan Type" (set to Medicaid / CHIP), with a "GO" button. A red box highlights the "Create Authorization" button in the top right. The main content area has a tab labeled "Authorizations" with sub-tabs for "Processed", "Errors", and "Disclaimer". A "Filter" button is on the right. A message states: "Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours." Below this, a light blue box says "There are no authorizations to show." At the bottom, there are links for "Terms and Conditions" and "Privacy Policy", both opening in new tabs, and a copyright notice for Centene Corporation.

Authorizations



- Enter the **Member ID or Last Name** and **Birthdate** and click **Find**.

A screenshot of the Superior Healthplan website's "Authorizations" section. The page has a dark blue header with navigation links: Eligibility, Patients, Authorizations (highlighted), Claims, Messaging, and Help. Below the header, there's a search bar with fields for "Viewing Authorizations For : TIN", "Plan Type" (set to "Medicaid / CHIP"), and a "GO" button. To the right, there's a search box with "Member ID or Last Name" (containing "123456789 or Smith") and "Birthdate" (containing "mm/dd/yyyy"), with a "Find" button. A pink box highlights the search fields. Below the search bar, there's a section titled "Authorizations" with tabs for "Processed", "Errors", and "Disclaimer". A "Filter" button is on the right. A message states: "Please call the health plan for questions regarding voided authorization submissions. The authorization page is updated every 24 hours." Below this, a light blue box says "There are no authorizations to show." At the bottom, there are links for "Terms and Conditions" and "Privacy Policy", and a copyright notice for Centene Corporation.

New Authorization Form



- **Select an Authorization Type** from the dropdown menu.

A screenshot of the Superior Healthplan web application interface for creating a new authorization. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a header section contains a "Viewing Authorizations For:" section with a TIN dropdown and a Plan Type dropdown set to "Medicaid / CHIP", followed by a green "GO" button and an orange "Create Authorization" button. The main content area is divided into two columns. The left column, titled "Authorization For", contains a "MEDICAID NBR:" field and a large text box with a close button (X) containing the following text: "After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 800-783-5386 (Option 7) for after-hours urgent admission, inpatient notifications or requests." The right column, titled "Enter Authorization", shows a progress bar with three steps: "1. PROVIDER REQUEST" (active), "2. REVIEW REQUEST" (disabled), and "3. FINISH UP" (disabled). A dropdown menu labeled "Select an Authorization Type" is highlighted with a red rectangle, and a "NEXT >" button is located below it.

Authorization Type



- Can be searched by **Requesting Provider NPI or Last Name**.
- Enter requesting provider NPI in field. If you do not know the requesting provider NPI enter their last name.

A screenshot of the Superior Healthplan web portal. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a search bar allows users to view authorizations by TIN and Plan Type (Medicaid / CHIP), with a "GO" button and a "Create Authorization" button. The main content area is divided into two columns. The left column, titled "Authorization For", contains a "MEDICAID NBR:" field and a large text box with a message about after-hours emergency and urgent admissions. The right column, titled "Enter Authorization", shows a "1. PROVIDER REQUEST" section with a dropdown menu for "Outpatient Medical", a "Lab Testing?" section with "Yes" and "No" radio buttons, and a highlighted text input field for "Requesting Provider NPI or Last Name". A "NEXT" button is located below this field. The bottom of the right column shows a "3. FINISH UP" section.

Requesting Provider – Search



- The search results will display all providers matching the search criteria and includes their specialty description in the **Specialty Desc** column.

Select a Provider X					
PROVIDER NAME	PHONE NUMBER	TAX ID	NPI	SPECIALTY DESC	SELECT
 SMITH AND NEPH					
 SMITH				SKILLED NURSING FACILITY	
SMITH 				GENERAL SURGERY	
SMITH, 				EMERGENCY MEDICINE	
SMITH. 				GENERAL SURGERY	
SMITH. 				HEMATOLOGY ONCOLOGY	
SMITH, 				INFECTIOUS DISEASE	
SMITH, 				FAMILY PRACTICE	

Same as Requesting Provider



- If the servicing provider is different from the requesting provider, use the **Servicing Provider** field to search by last name or NPI.
- Add service dates up to **30** days in advance, up to **6-month** span.
- The number of **Units/Visits/Days** can be entered here.
- Enter CPT code in **Primary Procedure** field.
- Additional CPT codes can be entered by clicking on the + icon beside **Add Additional Procedures**.
- For multiple lines of service, click the + icon to **Add New Service Line**.

A screenshot of the Superior Healthplan authorization form. The form is divided into two main sections: "Authorization For" on the left and "Enter Authorization" on the right. The "Authorization For" section contains fields for "DOB" and "MEDICAID NBR", a "PROVIDER REQUEST" section with a medical icon, "Service Type: Home Health", "DURABLE MEDICAL EQUIPMENT", "Primary Diagnosis: D2936: BENIGN NEOPLASM UNS EPIDIDYMIS", and fields for "NPI:", "TIN:", and "Phone:". Below this is a note: "If you need an authorization for an out-of-network provider, please contact 1-800-218-7508." The "Enter Authorization" section contains a "1. PROVIDER REQUEST" section with an "EDIT" button, a "2. SERVICE LINE" section with a "Now adding new service line" button, and a "3. FINISH UP" section. The "2. SERVICE LINE" section includes fields for "Servicing Provider", "NPI:", "TIN:", "Name:", "Start Date", "End Date", "Units/Visits/Days", "Primary Procedure" (with a "Procedure Code" field), "CODE LOOKUP", "+ Add Additional Procedures", and "+ Add New Service Line". Several fields in the "2. SERVICE LINE" section are highlighted with red boxes: "Servicing Provider", "Units/Visits/Days", "Primary Procedure", "Add Additional Procedures", and "Add New Service Line".

Complete Now



- Each service line will display with the provider information, procedure and place of service as they are added to the authorization.
- **Complete Now** will need to be reviewed.
- The portal user's name, phone, fax and email address will auto-populate into the contact information.
- **Add Comments** here if needed.

Authorization For

PROVIDER REQUEST

 **Anthony Smith** NPI: TIN: Phone: --
Primary Diagnosis: --

SERVICE LINES

If you need an authorization for an out-of-network provider, please contact 1-800-218-7508.

Service Line 1

 **Anthony Smith** NPI: TIN: Participating: Yes Phone: --
Dates: -- Units: -- Place Of Service: --

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
		Yes 	Complete Now	No 

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

CONTACT IQC

Phone

Fax

Email

Add Comments

Attachment:

Upload any relevant attachments. (20 MB limit)

Attachment name cannot contain any spaces or special characters.

[Choose File](#) No file chosen

Attachments



- Attach necessary documentation for a respective authorization here.
- Click on **Choose File** for the document, then click **Attach**.

Please note: There is an attachment upload limit of 20MB.

Authorization For

PROVIDER REQUEST

 **Anthony Smith** NPI: TIN: Phone: --
Primary Diagnosis: --

SERVICE LINES

If you need an authorization for an out-of-network provider, please contact 1-800-218-7508.

Service Line 1

 **Anthony Smith** NPI: TIN: Participating: Yes Phone: --
Dates: -- Units: -- Place Of Service: --

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
		 Yes	Complete Now	 No

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

CONTACT IQC

Phone

Fax

Email

[Add Comments](#)

Attachment:

Upload any relevant attachments. (20 MB limit)
Attachment name cannot contain any spaces or special characters.

Choose File No file chosen

Submit



- Once actions 1 through 3 have been completed, review by scrolling on the left side of the screen.
- If all information is accurate, click **Submit**.
- To make corrections, click **Edit** on actions 1 or 2 on the right-hand side of the screen.

Authorization For

PROVIDER REQUEST

 **Anthony Smith**
Primary Diagnosis:

NPI:
TIN:
Phone: --

SERVICE LINES

If you need an authorization for an out-of-network provider, please contact 1-800-218-7508.

Service Line 1

 **Anthony Smith**

Dates:
Units:
Place Of Service:

NPI:
TIN:
Participating: Yes
Phone: --

Procedure Code	Service Type	Auth Req'd?	Review Needed?	Review Completed?
		 Yes	Complete Now	 No

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)

2. SERVICE LINE [EDIT](#)

3. FINISH UP

Fax

Email

 Add Comments

Attachment:
Upload any relevant attachments. (20 MB limit)
Attachment name cannot contain any spaces or special characters.
[Choose File](#) No file chosen

[Attach](#)

[SUBMIT](#)

Confirmation



- A confirmation screen will appear once the prior authorization has been submitted successfully.
- Please keep record of this number to review status or for reference when calling Superior for assistance.

A screenshot of a web application showing an "Authorization Summary" window. The window displays patient information (DOB, Name, Date), the authorization number (7A3W-4NR7), and a table of submitted service lines. To the right, there is a sidebar with "Enter Authorization" steps and a "CONTACT IQC" section with contact information. At the bottom, there is a "Place Of Service" dropdown and a "Phone" field.

Authorization Summary

DOB:
Name:
Date: October 19, 2020 5:12:13 PM CDT

Authorization #: 7A3W-4NR7

Submitted Service Lines

Procedure Code	Service Type	NPI
00100	OS SP	
000	OS SP	

NOTE: Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual.

Place Of Service: Unspecified Phone: --813-972-7977

Enter Authorization

1. PROVIDER REQUEST [EDIT](#)
2. SERVICE LINE [EDIT](#)
3. FINISH UP

CONTACT IQC

Prince Vegeta

Phone
(111) 111-1111

Fax
(111) 111-1111

Email
1@tx.com

[Add Comments](#)

Note:
When selecting a Non-Participating Provider, you must include a comment about that selection. If you feel you have chosen a Non-Participating Provider in error you may edit your service line selection.



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Claims

Claims

- The **Claims** tab offers a summary of all claims activity for the previous 30 days.
- View each claim's details by clicking on the claim number in the **Claim No.** column.
- View the status of each claim in the **Claim Status** column.

A screenshot of the Superior Healthplan web portal. The top navigation bar includes links for Eligibility, Patients, Authorization, Claims (highlighted with a red box), Messaging, and Help. Below the navigation bar, there are filters for "Viewing Claims For: TIN" and "Plan Type: Medicaid / CHIP", along with a "GO" button and "Upload EDI" and "Create Claim" buttons. A reminder banner states: "Reminder: HHSC has updated the STAR+PLUS and STAR Kids bill code matrices effective 12/1/2022. Many of the bill code matrix updates also impact EVV in-scope services. Please reference the respective matrices on HHSC's website for more details: STAR Kids STAR+PLUS EVV". Below the banner, the "Claims" section is active, showing tabs for Individual, Saved, Submitted, Batch, Recurring, Payment History, and Claims Audit Tool. The "Claims: Recent" section displays a table of claims with a search bar and filter options. The table has columns for Claim No., Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status. The first column (Claim No.) and the last column (Claim Status) are highlighted with red boxes. The table shows six rows of claims, all with a status of "Paid".

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
Y237TXE	CMS-1500		08/23/2025 - 08/23/2025	\$81.00 / \$26.44	Paid
Y237TXE	CMS-1500		08/23/2025 - 08/23/2025	\$112.00 / \$27.48	Paid
Y237TXE	CMS-1500		08/23/2025 - 08/23/2025	\$272.00 / \$269.60	Paid
Y237TXE	CMS-1500		08/23/2025 - 08/23/2025	\$81.00 / \$26.44	Paid
Y237TXE	CMS-1500		08/23/2025 - 08/23/2025	\$81.00 / \$26.44	Paid
Y237TXE	CMS-1500		08/23/2025 - 08/23/2025	\$272.00 / \$269.60	Paid

Claim Search



- Enter 1 or more of the following search criteria:
 - **Member Details: Last Name or ID number**
 - **Claim Number**
 - **Date Range** (limited to a 1-month span and only the last 24 months of claims data is available online)

Please note: Claims update every 24 hours.

A screenshot of the "Claims Search" modal window. The modal has a title bar with a close button. Below the title, it says "Search by one or more of the following...". There are four search criteria sections, each with a text input field: "Member Details: Last Name or ID number", "Member Date of Birth" (with a "MM/DD/YYYY" placeholder), "Provider Details: NPI", and "Claim Number". Below these is a "Date Range" section with "From" and "to" date pickers, showing "07/19/2020" and "08/19/2020" respectively. At the bottom of the modal are "Search" and "Cancel" buttons. Below the buttons, there is a note: "Want to narrow your current results? [Use the Filter](#) instead." and a footer note: "Only the last 24 months of Claims data is available online. Claims update every 24 Hours." The background shows a blurred view of the main application interface with a table of claims data.

Claim Search



- When searching under the **Submitted** tab, you can enter the confirmation number, or search by a date range, and click **Go**.

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Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: TIN [dropdown] Plan Type: Medicaid / CHIP [dropdown] [GO]

[Upload EDI] [Create Claim]

Claims [Individual] [Saved] **Submitted** [Batch] [Recurring] [Payment History] [Claims Audit Tool] [Filter]

Claim Submission Dates:
From: 08/23/2025 To: 09/23/2025 Confirmation #: [input] Status: Select... [Go!]

To search, enter one or more of the following search criteria. The Submission Date range you provide is limited to a one-month span.

SUBMITTED STATUS ↑	DATE SUBMITTED ↑	WEB #/ REF # ↑	CLAIM NUMBER ↑	CLAIM TYPE ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑
🕒	09/09/2025		Y252TX	CMS-1500		608000221	X227TXE	\$379.00

One item found. Page 1/1 1

Claim Submission



- Select **Create Claim** from the **Claims** tab.

A screenshot of the Superior Healthplan navigation bar. The "Claims" tab is highlighted with a red box. Below the navigation bar, there are dropdown menus for "Viewing Claims For:" and "Medicaid / CHIP", a "GO" button, an "Upload EDI" button, and a red-bordered "Create Claim" button.

superior healthplan. Eligibility Patients Authorizations **Claims** Messaging Test Account

Viewing Claims For : [dropdown] Medicaid / CHIP [dropdown] GO Upload EDI **Create Claim**

- Enter the **Member ID** or **Last Name** and **Birthdate** for whom the claim will be submitted then click **Find**.

A screenshot of the Superior Healthplan search bar. The "Claims" tab is highlighted with a red box. Below the navigation bar, there are dropdown menus for "Viewing Claims For:" and "Medicaid / CHIP", a "GO" button, and a search section with "Member ID or Last Name" and "Birthdate" input fields, a "Find" button, and a red-bordered "X" button.

superior healthplan. Eligibility Patients Authorizations **Claims** Messaging Test Account

Viewing Claims For : [dropdown] Medicaid / CHIP [dropdown] GO Member ID or Last Name Birthdate [input] mm/dd/yyyy **Find** X

- Choose either the **CMS 1500** or **CMS UB-04** claim type.

A screenshot of the "Choose a Claim Type" screen. It features two main options: "CMS 1500" with a "Professional Claim →" button, and "CMS UB-04" with an "Institutional Claim →" button. Both buttons are highlighted with red boxes.

Choose a Claim Type

CMS 1500
Professional Claim →

CMS UB-04
Institutional Claim →

Claim Submission



- Required Fields:
 - **Patient Account Number**
 - **Statement Dates**
- Enter other pertinent information for the claim, as necessary.
- Use the field tabs to get additional details for entered information.

A screenshot of the "Professional Claim for" form, specifically the "General Info" section. The form is titled "THIS SECTION General Info" and includes a subtitle "Information about the dates of the claim." A progress bar at the top right shows "Your Progress" with a green arrow pointing right. The form contains several fields with red boxes highlighting the "Patient's Account Number*" and "Statement Dates*" fields. The "Patient's Account Number*" field is a text box with a placeholder "XXXXXXXXXX". The "Statement Dates*" field is a date range selector with "From" and "To" dropdowns, both showing "MM/DD/YYYY". Other fields include "Date of current illness, injury, pregnancy (IMP)", "Other Date", "Hospitalization", "Additional Claim Information", "Outside Lab?", "Prior Authorization Number", "CLIA Number", and "Amount Paid". Each field has a corresponding "Next" button on the right. The form is set against a light blue background with a white border.

Claim Submission



- Required Fields:
 - **ICD Version Indicator**
 - **Diagnosis Codes**

Professional Claim for Your Progress

THIS SECTION:
Diagnosis Codes
Diagnosis Code and Additional Insurance Information.

[< Back](#) [Next >](#)

* Required field

ICD Version Indicator* ☒ ICD 10 Please note that for the claim statement dates entered, valid ICD-10 codes only are accepted.

Diagnosis Codes* [Add](#) (Enter diagnosis code and click on Add button)

[Add Coordination of Benefits](#)

[< Back](#) [Next >](#)

Coordination of Benefits Claims



- Click **Add Coordination of Benefits** to include primary insurance information when applicable.
- New fields will appear to enter the **Carrier Type** and the primary insurance **Policy Number**.

Please note: If the member has more than 1 primary insurance (Medicaid would be the third payer), the claim cannot be submitted on the portal.

This screenshot shows the 'Add Coordination of Benefits' form. At the top, there is a field for 'Diagnosis Codes*' with the placeholder text 'XXXX e.g. V87' and an 'Add' button. To the right of this field is the instruction '(Enter diagnosis code and click on Add button)'. Below this, a row displays 'F431 -- POST-TRAUMATIC STRESS DISORDER PTSD' with a 'Remove X' button on the right. In the center of the form, the text 'Add Coordination of Benefits' is highlighted with a red rectangular box. At the bottom left is a 'Back' button, and at the bottom right is a 'Next' button with a right-pointing arrow.This screenshot shows the 'Primary Insurance' form. At the top, it says 'Primary Insurance' followed by a 'Remove X' button. Below this is a notice: 'Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.' The form contains two main fields: 'Carrier Type*' and 'Policy Number*'. The 'Carrier Type*' field has a dropdown menu that is open, showing three options: 'C50M -- Commercial', 'M5ED -- Medicare', and an option that is partially visible at the top. The 'Policy Number*' field contains the placeholder text 'XXXXXXXX'. A red rectangular box highlights both the 'Carrier Type*' dropdown and the 'Policy Number*' field. At the bottom left is a 'Back' button, and at the bottom right is a 'Next' button with a right-pointing arrow.

Claim Submission



- Required Fields:
 - **Dates of Service**
 - **Place of Service**
 - **Procedure Code**
- A maximum of 50 service lines can be entered for an individual claim.
- Additional service lines are entered using **+ New Service Line**.

Professional Claim for [redacted] Your Progress [progress bar]

THIS SECTION:
Service Lines
Enter maximum of 50 service lines.

← Back Next →

Total: \$1.00

+ New Service Line

PROCEDURE / CHARGES

1: / \$1.00

* Required field

Now Viewing Line 1: / \$1.00

24 a

Dates of Service* From 03/18/2017 To 03/18/2017

24 b

Place of Service* Select...

24 c EMG

Emergency Yes No

24 d

Procedure Code* XXXXX @

Modifiers XX Add Please enter the modifier and click the Add button.

Delete Save / Update

Claim Submission



- Required Fields:
 - **Diagnosis Code(s)**
 - **Charges**
 - **Days/Units**

A screenshot of a web-based claim submission form. The form is divided into several sections with labels on the left and input fields on the right. The sections include: "Diagnosis Code(s)*" with a checkbox for "2598 - OTHER SPECIFIED ENDOCRINE DISORDERS" and a label "24 e"; "Charges*" with a text input field containing "XX XX" and a label "24 f"; "Days / Units*" with a text input field containing "XX XXX" and a label "24 g"; "Family Planning" with radio buttons for "Yes" and "No", a label "EPSDT", a dropdown menu with "Select..." and a checkmark icon, and a label "24 h"; "NDC" with a text input field containing "NDC" and a label "NDC"; and "Supplemental Information" with a text input field containing "Supplemental Information". At the bottom right is an orange "Save / Update" button. At the bottom left is a grey "← Back" button, and at the bottom right is a green "Provider Details →" button.

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- Primary Insurance

Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Amount Allowed*

XXXX.XX

Deductible

XXXX.XX

Copay

XXXX.XX

Co-Insurance

XXXX.XX

Amount Paid

XXXX.XX

Service Line Denial Reasons

Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category

Select...

▼

Denied Amount

XXXX.XX

Add Denied Reason

Save / Update

← Back

Provider Details →

Coordination of Benefits Claims



- The **Primary Insurance** fields perform a calculation to ensure accuracy when billing.
- **Deductible + Copay + Co-Insurance + Amount Paid = Amount Allowed**

Primary Insurance
Notice: If the Member has more than one primary insurance (Medicaid would be the 3rd payer), the claim cannot be submitted through the Web.

Amount Allowed*	XXXX.XX	=
Deductible	XXXX.XX	}
	+	
Copay	XXXX.XX	
	+	
Co-Insurance	XXXX.XX	
	+	
Amount Paid		

Coordination of Benefits Claims



- **Service Line Denial Reasons** are used to indicate instances where the amount allowed is less than the charges. These can be indicated using the dropdown menu and entering the denied amount.
- **Add Denied Reason** must be clicked to include the **Denied Category** and **Denied Amount**.
- A new line will be created when the **Denied Category** has been successfully added to the service line.

The image shows two screenshots of the "Service Line Denial Reasons" form. The top screenshot shows the form with a dropdown menu open for the "Denied Category" field. The dropdown menu lists the following options: Select, Duplicate, Eligibility, Capitation, Over Allowable, Authorization, Timely Filing, Billing Error, Third Party, Adjustment, Non-Covered Service, Other, and Waiting for Information. The bottom screenshot shows the form with the "Denied Category" field set to "Select..." and the "Denied Amount" field set to "XXXX.XX". The "Add Denied Reason" button is visible at the bottom of the form, and a "Remove X" button is located in the bottom right corner.

Coordination of Benefits Claims



- Final Calculations:
 - Total of the **Amount Allowed** and **Denied Amount** must equal the **Charges**.

Please note: Denied Category and Denied Amount are not required and can be left blank when appropriate.

A screenshot of the Superior Healthplan claims form. The form is divided into sections: "Charges*", "Primary Insurance", "Service Line Denial Reasons", and "Denied Amount". The "Charges*" field contains "XX.XX" and is highlighted with a red box. The "Amount Allowed*" field contains "50" and is also highlighted with a red box. The "Deductible", "Copay", and "Co-Insurance" fields all contain "XXXX.XX". The "Amount Paid" field contains "50". The "Service Line Denial Reasons" section has a "Denied Category" dropdown menu set to "Select...". The "Denied Amount" field contains "XXXX.XX" and is highlighted with a red box. Red arrows and plus signs indicate the calculation: "Charges*" equals "Amount Allowed*" plus "Denied Amount". A red box is also present around the "Charges*" field.

Charges* XX.XX =

Amount Allowed* 50 +

Deductible XXXX.XX

Copay XXXX.XX

Co-Insurance XXXX.XX

Amount Paid 50

Service Line Denial Reasons

Select denied category, enter amount and click "Add Denied Reason" to add a denied amount to your claim.

Denied Category Select... [v]

Denied Amount XXXX.XX +

Claim Submission



- **Save/Update** must be clicked to enter each service line.
- **Next** will be greyed out and un-clickable until the first service line is saved.

A screenshot of a web application interface for claim submission. It features a light grey header bar with a "Save / Update" button on the right, which is highlighted by a red arrow. Below the header is a main content area with a "← Back" button on the left and a "Next →" button on the right. The "Next →" button is highlighted with a red border, indicating it is the next step in the process.

Claim Submission



- Enter pertinent provider information for **Referring Provider** and **Rendering Provider**.

Please note: Only enter Rendering Provider information if it is not the same as Billing Provider information.

A screenshot of the Superior Healthplan Professional Claim form. The form is titled "Professional Claim for" and shows a progress bar. The "Providers" section is highlighted. It contains two main sections: "Referring Provider" and "Rendering Provider". The "Referring Provider" section has fields for NPI, Last Name or Organizational Name, and First Name. The "Rendering Provider" section has fields for NPI, Tax ID, Last Name or Organizational Name, and First Name. There are "Find Provider" buttons for both sections. The form is numbered 17 and 24.

Claim Submission



- **Billing Provider** information is required and must be completed for each claim submission.
- Click on the **Next** button to continue.

Billing Provider

Tax ID

Name*

Last Name

NPI

XXXXXXXXXX

Taxonomy #*

XXXXXXXXXX

Address*

XXXXXXXXXX

City*

XXXXXXXXXX

State*

Select...

Zip*

XXXXX

Service Facility Location

Same As Billing Provider

Name

Last Name

NPI

XXXXXXXXXX

Address

XXXXXXXXXX

City

XXXXXXXXXX

State

Select...

Zip

XXXXX

← Back

Next →



Claim Submission



- Add **Attachments**, if applicable.
- **Browse** for the document, select an **Attachment Type** and then **Attach**.
- If there are no attachments, click **Next**.

Please note: There is a 30MB limit and only .jpg, .tif, .pdf and .tiff are supported file types for attachments

Professional Claim for [] Your Progress [] [] [] [] []

THIS SECTION: **Attachments** Add attachments to the claim (5MB limit). Supported types are .jpg, .tif, .pdf and .tiff

Attachments

File* [] Browse... Attachment Type* Select Type... [v] [] Attach

Attachment Name	Type	
TX_TX_2148131_Claim Attachment example.pdf	Primary Carrier EOB	Remove X

[Back] If there are no attachments, click Next. [Next]

Claim Submission



Almost done!

- Portal claims follow the same submission guidelines and standards as any other claim. Improper coding can result in claim denials.
- Please take this time to review the claim before submitting.
- Click **Submit** when the claim is complete.

Professional Claim for [redacted] Your Progress [progress bar]

THIS SECTION:
Review Please review your claim and submit.

Almost done! You can go back to review your claim or submit now. [Submit →](#)

Claim Id: 207199471
Member Record Number: [redacted]
Member Claim Amount Paid: [redacted]
Patient's Account Number: [redacted]

General Info
Hospitalized From:
Hospitalized To:
Outside Lab?: No
Outside Lab Amount:
Prior Authorization Number:
CLIA Number:

Diagnosis Codes
2598 -- OTHER SPECIFIED ENDOCRINE DISORDERS

Service Lines

Line	From	To	Place	Proc	Diagnosis	Amount	Days/Units	Family Plan	EPSDT	NDC	Supplemental Info
1	03/17/2015	03/18/2015	12	99213 ()	2598	\$344.00	1	No			

Providers

Provider Type	Name	Tax ID	NPI	Taxonomy	Address
ReferringProvider					
RenderingProvider					
BillingProvider					
Service Facility Location					

Attachments
• Attachment Name=TX_TX_2148131_Claim Attachment example.pdf

[← Back](#) [Submit →](#)

Claim Submission



- **Your Web/Ref#** (Web Reference Number) will be useful when discussing a claim that has been submitted through the portal with your Provider Representative.
- The number given here is not a claim number but merely helps to identify a claim submitted using the secure portal.

A screenshot of the Superior Healthplan web portal. The top navigation bar includes the Superior Healthplan logo and several menu items: Eligibility, Patients, Authorizations, Claims, and Messaging. Below the navigation bar, there is a section for "Viewing Claims For:" with a dropdown menu set to "Medicaid / CHIP" and a green "GO" button. To the right of this section are two buttons: "Upload EDI" and "Create Claim". The main content area displays a "Success" message with the text "Congratulations!" and a white box containing the following information:

Your claim has been submitted
Your Web/Ref# is 500006538

Claim Corrections/Appeals



- Denied or partially paid claims can be corrected/appealed online.
- Click on the **Claim No.** to see the details and begin the correction/appeal process.
- Use the **Claim Status** to easily identify those claims that have been denied.

The screenshot shows the Superior Healthplan Claims portal. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for "Viewing Claims For" includes a TIN dropdown, a Plan Type dropdown set to "Medicaid / CHIP", and a "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. A light blue banner contains a reminder about updated STAR+PLUS and STAR Kids bill code matrices. Below this is a "Claims" section with tabs for Individual, Saved, Submitted, Batch, Recurring, Payment History, and Claims Audit Tool. The "Claims: Recent" section features a search bar with a date range of "08/23/2025 to 09/23/2025" and a "Filter" button. A table displays recent claims with columns for Claim No., Claim Type, Member Name, Service Date(s), Billed/Paid, and Claim Status. Two rows are visible, both with a status of "Denied". The "CLAIM NO." and "CLAIM STATUS" columns are highlighted with red boxes.

CLAIM NO.	CLAIM TYPE	MEMBER NAME	SERVICE DATE(S)	BILLED/PAID	CLAIM STATUS
Y238TXE	CMS-1500		08/23/2025 - 08/23/2025	\$446.00 / \$0.00	❌ Denied
Y244TXE	CMS-1500		08/23/2025 - 08/23/2025	\$343.00 / \$0.00	❌ Denied

Claim Corrections/Appeals



- Use the **Correct Claim** or **Appeal Claim** button to begin the process. Each screen of the claim will be visible so updates can be made as necessary, then re-submitted.

*Please note: The **Providers** section will be visible, but changes can no longer be made. If this section needs to be modified, a new claim must be submitted.*

The screenshot displays the 'Claim Details' page for a denied claim (#U049). The interface includes a top navigation bar with links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are filters for 'Viewing Claims For' (TIN) and 'Plan Type' (Medicaid / CHIP), along with 'Upload EDI' and 'Create Claim' buttons.

The main section shows the claim status as 'Denied' with a red 'X' icon. Below this, there are buttons for '+ Copy Claim', 'Correct Claim' (highlighted with a red box), 'Appeal Claim' (highlighted with a red box), 'Void/Recoup Claim', and 'Reconsider Claim'.

A progress bar indicates the claim's history: 'Claim Accepted' (green checkmark), 'In Process' (green checkmark), and 'Denied' (red X).

The claim details are organized into four columns: Member, Provider, Claim, and Most Recent Payment.

Member	Provider	Claim	Most Recent Payment
Member Name: [Redacted]	Ref/Acct No.: [Redacted]	DOS Range: 02/16/2021 - 02/16/2021	Payment Date: 02/25/2021
Member ID: [Redacted]	Servicing Provider: [Redacted]	Received Date: 02/18/2021	Check/EFT Number: [Redacted]
Member DOB: [Redacted]	Servicing NPI: [Redacted]	Billed Amount: \$ [Redacted]	Check Dated: [Redacted]
			Paid Claim Amount: \$ [Redacted]
			Total Check Amount: \$ [Redacted]

Below the claim details is a 'Service Lines' section with a table showing the specific services billed.

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status	Payment Codes
1	02/16/2021	T1015	Z0289, L309, R21, Z760	AM	72	\$ [Redacted]	\$0.00	02/25/2021		⊗ DENY	47

Copy Claim

- Click **Copy Claim** to copy, edit or resubmit claims for the same member.
- The information from the claim being copied is entered into a new claim submission form.



superior healthplan.

Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For : TIN [redacted] Plan Type Medicaid / CHIP GO Upload EDI Create Claim

Back to Claims Claim Details

Claim #U054 [redacted]: Paid

+ Copy Claim Correct Claim Appeal Claim Void/Recoup Claim Reconsider Claim

Claim Accepted In Process Paid

Member Member Name: [redacted] Member ID: [redacted] Member DOB: [redacted]

Provider Ref/Acct No.: [redacted] Servicing Provider: [redacted] Servicing NPI: [redacted]

Claim DOS Range: 02/17/2021 - 02/17/2021 Received Date: 02/23/2021 Billed Amount: \$ [redacted]

Most Recent Payment Payment Date: [redacted] Check/EFT Number: [redacted] Check Dated: [redacted] Paid Claim Amount: [redacted] Total Check Amount: [redacted]

Service Lines

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	APPLIED INCOME	Paid Amount	Payment Date	Check/EFT Number	Status	Payment Codes
1	02/17/2021	A0427	R0602, Z743	ET, RH	41	\$ [redacted]	\$0.00	\$ [redacted]	03/02/2021		PAID	92
2	02/17/2021	A0425	R0602, Z743	ET, RH	41	\$ [redacted]	\$0.00	\$ [redacted]	03/02/2021		PAID	92

Void/Recoup Claims



- Select **Void/Recoup Claim** to:
 - Void a submitted claim.
 - Recoup any over-payments.

The screenshot displays the "Claim Details" page for Claim #U075, which is in a "Pending" status. The interface includes a navigation bar with tabs for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below the navigation bar, there are filters for "Viewing Claims For:" (TIN) and "Plan Type" (Medicaid / CHIP), along with "GO", "Upload EDI", and "Create Claim" buttons.

The "Claim Details" section shows a progress bar with three stages: "Claim Accepted" (checked), "In Process" (checked), and "Paid/Denied" (unchecked). Below the progress bar, there are four tabs: "Member", "Provider", "Claim", and "Most Recent Payment".

The "Member" tab shows fields for Member Name, Member ID, and Member DOB. The "Provider" tab shows fields for Ref/Acct No., Servicing Provider, and Servicing NPI. The "Claim" tab shows fields for DOS Range (02/17/2021 - 02/18/2021), Received Date (03/15/2021), and Billed Amount (\$). The "Most Recent Payment" tab shows fields for Payment Date, Pending Claim Amount (\$), Check/EFT Number, Total Check Amount, and Check Dated.

Below the tabs is a "Service Lines" section with a table listing the services. The table has columns for Line, DOS, Proc, Dx, Modifiers, Place of Service, Charged, Paid Amount, Payment Date, Check/EFT Number, and Status.

Line	DOS	Proc	Dx	Modifiers	Place of Service	Charged	Paid Amount	Payment Date	Check/EFT Number	Status
1	02/17/2021		T182XX A Z20822, Z880		23	\$	\$			Pending

Reconsider Claim

- Select **Reconsider Claim** to submit the claim for reconsideration.

Please note: Information cannot be updated on the claim. Only attachments are allowed for submitting a reconsideration.

A screenshot of the Superior Healthplan web portal. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there's a section for "Viewing Claims For:" with fields for TIN and Plan Type, and a "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. The main content area is titled "Claim Details" and shows a "Claim # [redacted] Paid" status. Below this are buttons for "+ Copy Claim", "Correct Claim", "Appeal Claim", "Void/Recoup Claim", and "Reconsider Claim" (which is highlighted with a red box). A progress bar shows three steps: "Claim Accepted" (checked), "In Process" (checked), and "Paid" (checked). Below the progress bar are four sections: "Member" (Member Name, Member ID, Member DOB), "Provider" (Ref/Acct No., Servicing Provider, Servicing NPI), "Claim" (DOS Range, Received Date, Billed Amount), and "Most Recent Payment" (Payment Date, Paid Claim Amount, Check/EFT Number, Total Check Amount, Check Dated). At the bottom is a "Service Lines" table with columns: Line, DOS, Proc, Dx, Modifiers, Place of Service, Charged, Paid Amount, Payment Date, Check/EFT Number, Status, and Payment Codes. The first row of the table shows a service line with a status of "Paid".

Saved Claims



- Every claim that has been started but not submitted can be found in the **Saved** claims section.
- The portal automatically saves claim submission progress to ensure no work is lost.

A screenshot of the Superior Healthplan web portal. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, there are filters for "Viewing Claims For:" (TIN) and "Plan Type" (Medicaid / CHIP), with a "GO" button. To the right are buttons for "Upload EDI" and "Create Claim". A light blue banner contains a reminder about updated bill code matrices. Below the banner, the "Claims" section has several tabs: "Individual", "Saved" (highlighted with a red box), "Submitted", "Batch", "Recurring", "Payment History", and "Claims Audit Tool". Under the "Saved" tab, there are three sub-tabs: "Drafts", "Professional Ready to be Submitted", and "Institutional Ready to be Submitted". A table displays a list of saved claims with columns for Date Created, Claim Type, Claim ID, Member Name, Member ID, Original Claim #, and Total Charges. Each row includes "Edit" and "Delete" links.

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Eligibility Patients Authorizations Claims Messaging Help

Viewing Claims For: TIN Plan Type Medicaid / CHIP GO

Upload EDI Create Claim

Reminder: HHSC has updated the STAR+PLUS and STAR Kids bill code matrices effective 12/1/2022. Many of the bill code matrix updates also impact EVV in-scope services. Please reference the respective matrices on HHSC's website for more details: STAR Kids STAR+PLUS EVV

Claims Individual **Saved** Submitted Batch Recurring Payment History Claims Audit Tool

Claims listed below have missing information or contain errors. Click 'Edit' to view a claim, then fix any errors or complete it before submitting.

Drafts Professional Ready to be Submitted Institutional Ready to be Submitted

DATE CREATED ↑	CLAIM TYPE ↑	CLAIM ID ↑	MEMBER NAME ↑	MEMBER ID ↑	ORIGINAL CLAIM # ↑	TOTAL CHARGES ↑		
08/20/2025	CMS-1500					\$985.00	Edit	Delete
07/22/2025	CMS-1500					\$973.00	Edit	Delete
07/21/2025	CMS-1500					\$892.00	Edit	Delete

Recurring Claims



- Use the **Recurring** claim button to create multiple claims with pre-made templates for more efficient billing.
- Start by selecting a **Claim Type** from the dropdown.
- Refer to the Coding Guide for a list of pre-coded items.

A screenshot of the Superior Healthplan Claims portal. The top navigation bar includes buttons for 'Claims', 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring' (highlighted with a red box), 'Payment History', and 'Claims Audit Tool'. Below this, a 'Get Started' section mentions 'Used only by LTC and ADC Providers' and links to a 'Coding Guide'. A 'Your Progress' section shows a progress bar. The main content area features a 'Claim Type:' dropdown menu (highlighted with a red box) with a list of options: HCFA 1500, Assisted Living/Residential Care, Minor Home Modifications, Emergency Response, Personal Attendant Services, Adult Day Care, Nursing Services - RN, Nursing Services - LVN, Physical Therapy in the Home, Speech Therapy in the Home, and Occupational Therapy in the Home. To the right, there is a section titled 'Select a Template to Start Your Claim' with a document icon and the text 'Our preset templates help speed up the claims process.' At the bottom, there is a 'Privacy Policy' link and a copyright notice for Centene Corporation.

Please note: This tool is to be used only by Long Term Care (LTC) and Adult Day Care (ADC) providers.

Recurring Claims



- Select the desired service **Location** from the dropdown.

Get Started Used only by LTC and ADC Providers. [Coding Guide](#) Your Progress

Claim Type: **Assisted Living/Residential Care** Change

Location: 

Select a Service Location
Choose which location you would like to use with this template.

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NPI: Medicaid #:
NPI: Medicaid #:
NPI: Medicaid #:
NPI: Medicaid #:

Recurring Claims



- Click on **View Member List**.
- Member lists only need to be created once during your first time using the tool.

Get Started Used only by LTC and ADC Providers. [Coding Guide](#)

Your Progress

Claim Type: **Assisted Living/Residential Care** ▼ Change

Location: **MOAZAM, MUSTAFA** ▼ Change

NPI: [REDACTED] | Medicaid #: [REDACTED]
[REDACTED] HORIZON BLVD, HORIZON CITY, TX 79928

Click to View Your Member List → [View Member List →](#)

Recurring Claims



- To **Add Member**, enter the **Member ID or Last Name** and **Birthdate**.

Member List [Coding Guide](#)

Claim Type: **Assisted Living/Residential Care** [\(change\)](#)

Location: [\(change\)](#)

Taxonomy *:

* = Required
** = Up to 4 modifiers may be entered, separated by commas

Select	Member Name	Member ID	Modifier**	DOS Start*	DOS End *	Total Charges *	Days/Units *	Action
☐			XX,XX,XX,XX	MM/DD/YYYY	MM/DD/YYYY	XX.XX	XXXX	✕
				MM/DD/YYYY	MM/DD/YYYY	Update All DOS	XXXX	Update All Units
						Create Claim(s)		

Your Progress

Member ID or Last Name Birthdate

✕

Recurring Claims



- Once members are added, you will be alerted with a **Member Added** remark.
- Members will be listed in alphabetical order by last name.
- Under **Action**, click the **X** to remove a member from your list.

Member List [Coding Guide](#)

Your Progress

Claim Type: **Assisted Living/Residential Care** [\(change\)](#)

Location: [\(change\)](#)

Taxonomy *:

[Add Member](#)

* = Required
** = Up to 4 modifiers may be entered, separated by commas

Member Added.

Select	Member Name	Member ID	Modifier**	DOS Start*	DOS End *	Total Charges *	Days/Units *	Action
☐			XX,XX,XX,XX	MM/DD/YYYY	MM/DD/YYYY	XX.XX	XXXX	X
☐			XX,XX,XX,XX	MM/DD/YYYY	MM/DD/YYYY	XX.XX	XXXX	X
						MM/DD/YYYY	MM/DD/YYYY	Update All DOS
							XXXX	Update All Units
Create Claim(s)								

Recurring Claims



- **Create Claim(s)** by selecting the appropriate **Member Name** from the Members Listed.
- Enter all required information and click **Create Claim(s)**.
- Click on **X** under **Action** to delete the claim.

Please note: To save time, if the DOS Start and DOS End are the same for all checked members, enter at bottom and click Update All DOS.

The screenshot shows the "Recurring" tab in the Claims section. It includes a "Member List" with a "Coding Guide" link. Below this, there are fields for "Claim Type: Assisted Living/Residential Care", "Location", "NPI", and "Medicaid#". A "Taxonomy" dropdown is also present. A "Your Progress" bar shows "Add Member" as the next step. The main table lists members with columns for "Select", "Member Name", "Member ID", "Modifier", "DOS Start", "DOS End", "Total Charges", "Days/Units", and "Action". A red box highlights the "Select" column, showing "All" and "Member Name" options. Another red box highlights the "Action" column, showing a red "X" icon. At the bottom, there are buttons for "Update All DOS", "Update All Units", and "Create Claim(s)".

Select	Member Name	Member ID	Modifier**	DOS Start*	DOS End*	Total Charges*	Days/Units***	Action
☐	MIQ	75-33	XX,XX,XX,XX	MM/DD/YYYY	MM/DD/YYYY	XX.XX	XX.XX	X

MM/DD/YYYY MM/DD/YYYY Update All DOS XX.XX Update All Units Create Claim(s)

Recurring Claims



- Certify the claims being submitted are accurate.
- You can review claims prior to submitting. To review, click on the **eye icon** under **Action**.

Claims to Submit (1) [Coding Guide](#)

Your Progress

Claim Type: **Assisted Living/Residential Care**
Location:

Claim(S) created successfully.

Member Name	Member ID	Modifier	DOS Start	DOS End	Total Charges	Days/Units	Action
							 

☐ I certify that these claims are accurate.

[← Back](#) [Submit Claim\(s\)](#)

Recurring Claims



- You can review the claim or change some of the fields pre-coded for you.
- Some fields may not allow edits. If those fields need to be changed, you will need to delete the claim and start over.
- Click the **Close** button once you are finished reviewing/editing the claim.

The screenshot shows the 'Review Claim' window in the Superior Healthplan system. The window has a dark blue header with the Superior Healthplan logo and navigation tabs: Eligibility, Patients, Authorizations, Claims, Messaging, and Test Account. The main content area is titled 'Review Claim:' and contains several sections:

- Member Name:** A text field with a blue background.
- Member Account Number:** A text field with a blue background.
- General Info** [Edit](#): A section with fields for Prior Authorization Number, Hospitalized From, and Hospitalized To.
- Diagnosis Codes**: A list of codes, including '1. 7999 -- OTH UNKN&UNS CAUSE MORBDTY/MRTALTY'.
- Service Lines** [Edit](#) [Add New](#): A section with a table for service lines. The table has columns: From, To, Place, Proc, Diagnosis, Amount, Days/Units, Modifier, and NDC. The table is currently empty.
- Providers**: A section with a table for providers. The table has columns: Provider Type, Name, Tax ID, NPI, Member #, Taxonomy, and Address. The table is currently empty.

A 'Close' button is located in the bottom right corner of the window.

Recurring Claims



- After the claims have been reviewed for accuracy, select **I certify that these claims are accurate** and click **Submit Claim(s)**.

Claims to Submit (1) [Coding Guide](#) Your Progress

Claim Type: Assisted Living/Residential Care
Location:

Claim(S) created successfully.

Member Name	Member ID	Modifier	DOS Start	DOS End	Total Charges	Days/Units	Action
							eye x

☐ I certify that these claims are accurate.

Recurring Claims



Success! Your claims have been submitted!

- The **Web Reference#** (web reference number) will be useful when discussing claims submitted through the portal with your Provider Representative.
- The number given here is not a claim number. This number merely helps to identify a claim submitted using the portal.
- Click **Print** to print a copy of the claims submitted, including the web reference number.
- Click **Submit More Claims** to request a new template or to move on to other functions.

Claims Submitted (1) [Coding Guide](#)

Your Progress

Claim Type: **Assisted Living/Residential Care**
Location:

Success! Your claims have been submitted.

Date: 03/20/2015
Web Reference#: 506607082

Member Name	Member ID	Modifier	DOS Start	DOS End	Total Charges	Days/Units

Submit More Claims

Print

Please note: Claims may take up to 24 hours to be viewable on this site.

Payment History



- Recent payment activity can be found in **Payment History**.
- The **Check Date** is also a link to view the EOP for the **Payment Amount**.
- The selected EOP will appear in **PDF** format at the bottom left-hand side; click to **Open** the PDF file.

The screenshot shows the Superior Healthplan web portal. At the top, there's a navigation bar with links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a section for "Viewing Claims For" includes a TIN dropdown, a Plan Type dropdown set to "Medicaid / CHIP", and a "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. The main content area has a "Claims" tab selected, with sub-tabs for Individual, Saved, Submitted, Batch, Recurring, and Payment History (which is highlighted with a red box). A "Filter" button is also present. Below the tabs, the "Transactions" section shows activity between 07/10/2021 and 08/10/2021. An instruction box states: "Click on the Check Date to view the PDF of payment details from your payment provider. The PDF will open in a new window where you can save or print it. If there are any discrepancies on your payment details, please contact Provider Services." A table lists transactions with columns: CHECK DATE, CHECK NUMBER, CHECK CLEAR DATE, MAILING ADDRESS, and PAYMENT AMOUNT. The first row has a "CHECK DATE" of "07/13/2021 (PDF)" which is highlighted with a red box. A context menu is open over this date, showing options: "Open", "Open with system viewer", "Always open in Adobe Reader", "Show in folder", and "Cancel". At the bottom left, a file download bar shows a PDF icon and the text "...pdf". A "Show all" button is at the bottom right.

CHECK DATE ↑	CHECK NUMBER ↑	CHECK CLEAR DATE ↑	MAILING ADDRESS ↑	PAYMENT AMOUNT ↑
07/13/2021 (PDF)		EFT		\$175.00
07/14/2021 (PDF)		EFT		\$880.46
07/15/2021 (PDF)		EFT		\$4,594.80
07/15/2021 (PDF)		EFT		\$994.21
07/22/2021 (PDF)		EFT		\$236.25
07/22/2021 (PDF)		EFT		\$183.75
07/26/2021 (PDF)				\$0.00
07/27/2021 (PDF)				\$3,937.71

Claims Audit Tool

- Select the **Claims Audit Tool**.
- Click **Submit** to enter McKesson's Clear Claim Connection page.

A screenshot of the Superior Healthplan web application. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Test Account. Below this is a section for "Viewing Claims For:" with a dropdown menu set to "Medicaid / CHIP" and a "GO" button. To the right are "Upload EDI" and "Create Claim" buttons. A secondary navigation bar shows tabs for Claims, Individual, Saved, Submitted, Batch, Recurring, Payment History, My Downloads, and Claims Audit Tool (which is highlighted with a pink box). Below the navigation bar, the "PASS-THROUGH TERMS AND CONDITIONS" section is visible, containing several paragraphs of legal text. At the bottom right of this section are "Reject" and "Submit" buttons.

Claims Audit Tool



- Test claim coding by entering core information to be audited before submitting the live claim.

McKESSON

Clear Claim Connection

Sign Out Help

McKesson Edit Development

Glossary

About

CLAIM ENTRY

Clear

Review Audit Results

Claim Type

Professional

Gender

☒ Male ☐ Female

Date of Birth

ICD Code Set

☐ ICD9 ☒ ICD10

Diagnosis Codes

1 2 3 4

Bill Type

For quick entry, use your Down Arrow key after you enter a procedure code. Qty will default to 1, Billed Amount will default to 100, Date of Service From and To will default to today's date, and Place of Service will default to 11 (Office). Tabbing through these same fields will give you the same defaults.

LINE	PROCEDURE	MOD1	MOD2	MOD3	MOD4	QTY	REV CODE	BILLED AMT.	DOS FROM	DOS TO	PLACE OF SERVICE	PROVIDER STATE	LINE DIAG. 1	LINE DIAG. 2	LINE DIAG. 3	LINE DIAG. 4	LINE DIAG. 5	LINE DIAG. 6
1																		
2																		
3																		
4																		
5																		

Add More Procedures >>



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Secure Messages

Secure Messages



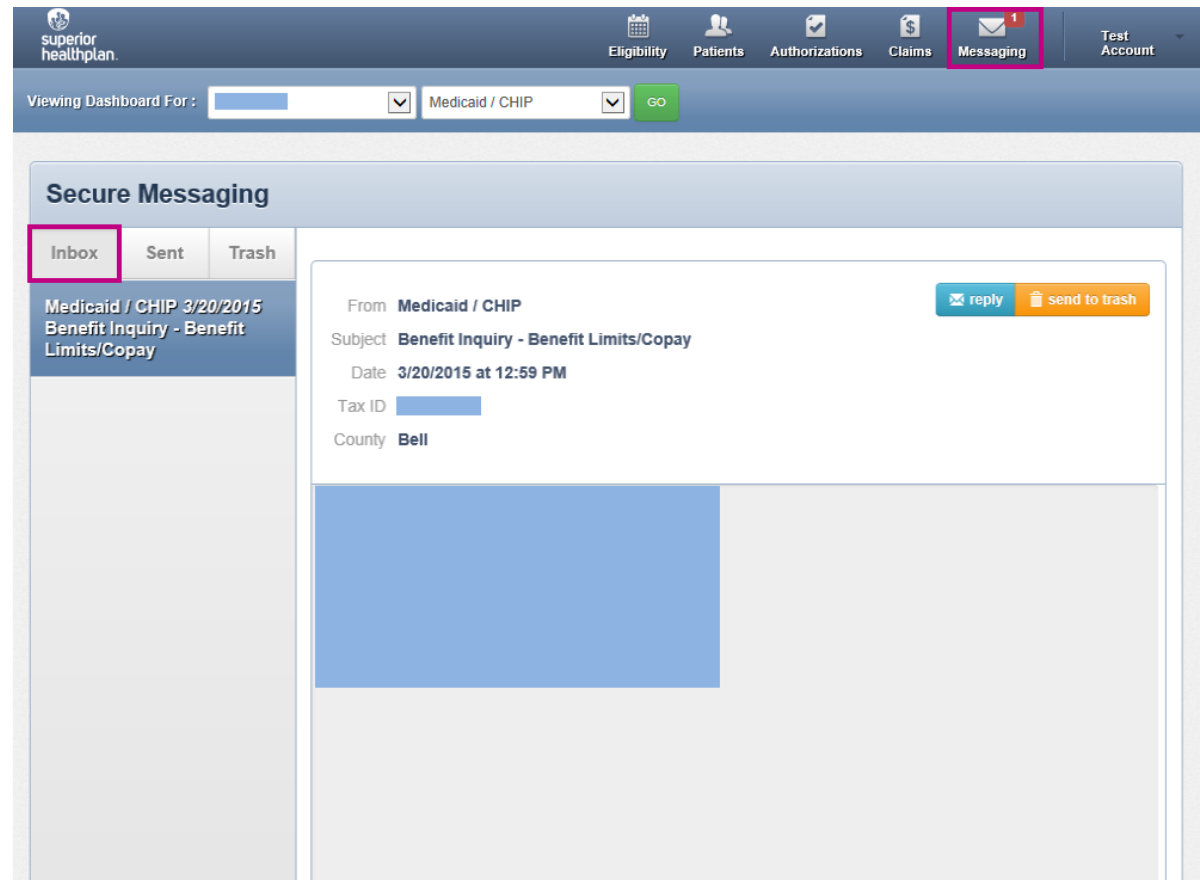
- Click on **Messaging** to access Secure Messaging which offers another way for safe communication between the plan and provider.
- Specific questions related to eligibility, authorizations and claims can be asked directly online.

A screenshot of the Superior Healthplan web portal. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging (highlighted), and Test Account. Below the navigation bar, there's a section for "Viewing Dashboard For:" with a dropdown menu set to "Medicaid / CHIP" and a "GO" button. The main content area is titled "Secure Messaging" and features a sidebar with "Inbox", "Sent", and "Trash" tabs. The "Inbox" tab is active, showing a list of messages. The selected message is from "Medicaid / CHIP" dated "3/20/2015" with the subject "Benefit Inquiry - Benefit Limits/Copay". The message body shows fields for "From", "Subject", "Date", "Tax ID", and "County", with the "County" field set to "Bell". There are "reply" and "send to trash" buttons in the top right corner of the message view.

Secure Messages



- The **Inbox** displays any new messages. Click on a message subject to read its contents.
- New messages are indicated by a number in red to the upper-right of the **Messaging** tab.



Secure Messages



- All sent messages can be viewed under the **Sent** messages section.
- Any deleted messages are sent to **Trash**. If needed, these messages can still be recovered.

Secure Messaging

Inbox **Sent** Trash

Medicaid / CHIP 3/20/2015
Benefit Inquiry - Benefit Limits/Copay

To: Medicaid / CHIP [send to trash](#)

Subject: Benefit Inquiry - Benefit Limits/Copay

Date: 3/20/2015 at 12:59 PM

Tax ID: [REDACTED]

County: Bell

[REDACTED]

Secure Messaging

Inbox Sent **Trash**

No Messages to display

No Message to display

Items will be deleted after 30 days.

Secure Messages

- Click **Create Message** to compose a new secure message.
- When you have finished creating your message, click the **Send** button.



Secure Message Subjects

A screenshot of the Superior Healthplan web portal's "New Message" form. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Test Account. Below the navigation bar, there's a "Viewing Messages For:" section with a dropdown menu set to "Medicaid / CHIP" and a "GO" button. A red arrow points to the "Create Message" button. The main form area is titled "New Message" and contains fields for "To" (Medicaid / CHIP), "Subject" (Benefit Inquiry - Benefit Limits/Copay), "County" (Select a County), "Member ID / CHIP ID" (123456789), and "Date of Birth" (mm/dd/yyyy). A large text area labeled "Your Message" is provided for the user to type. At the bottom, there are "send" and "cancel" buttons.

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Eligibility Patients Authorizations Claims Messaging Test Account

Viewing Messages For: Medicaid / CHIP GO

Create Message

New Message

If your message is about a specific member, please include their ID and Date of Birth below.

To: Medicaid / CHIP Member ID / CHIP ID: 123456789

Subject: Benefit Inquiry - Benefit Limits/Copay Date of Birth: mm/dd/yyyy

County: Select a County

Your Message

send cancel

A screenshot of a list of secure message subjects. The list is titled "Select a subject" and contains the following options: Claim Adjustment for up to 9 claims (PS), Claim Payment (PS), Claim Status (PS), Contract Clarification (PR), Eligibility Inquiry (PS), Member/Patient Problem (PR), Notification of Pregnancy (PR), Other (PS), Provider Panel Question (PR), Provider Relations Visit Request (PR), Service Coordinator (SH), Transition Specialist (SH), and Web Portal Issue (WEB).

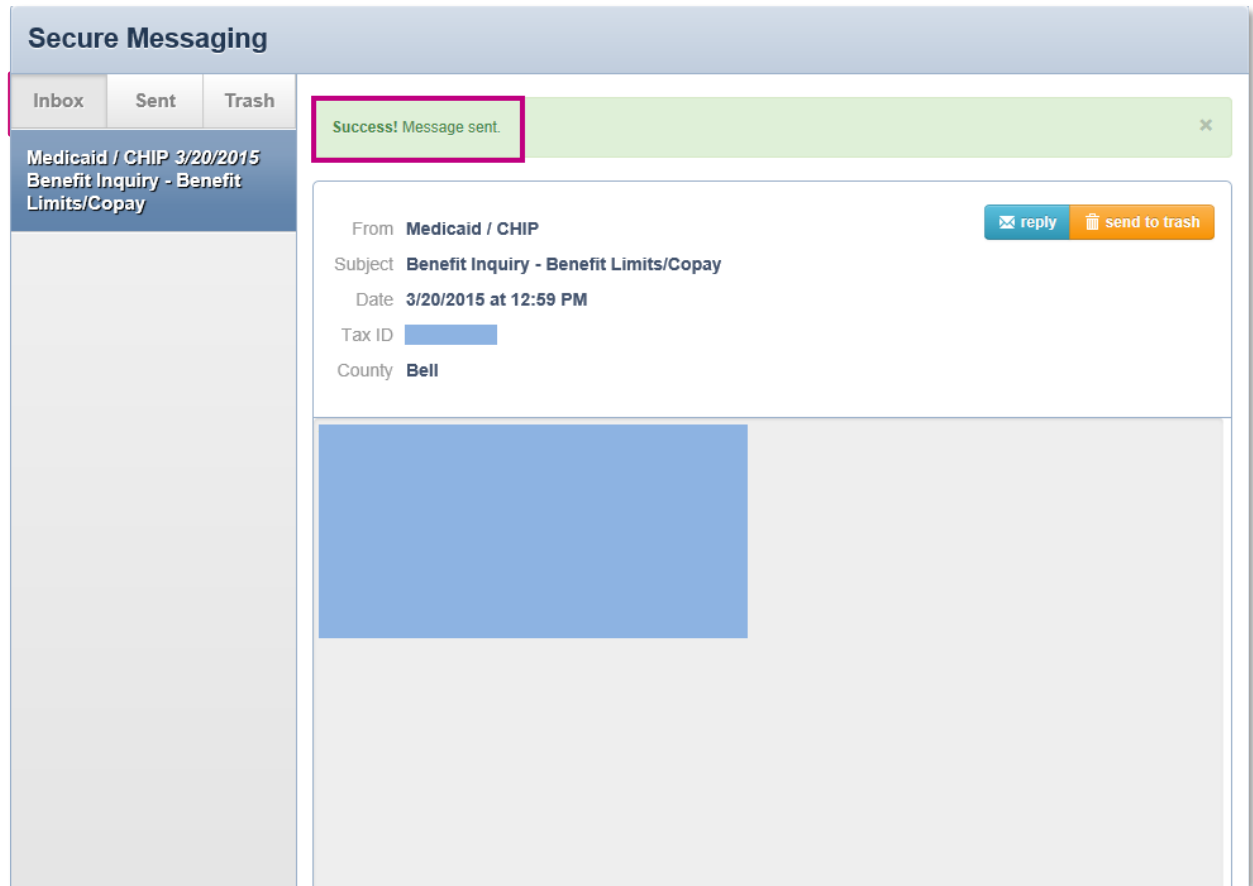
Select a subject

- Claim Adjustment for up to 9 claims (PS)
- Claim Payment (PS)
- Claim Status (PS)
- Contract Clarification (PR)
- Eligibility Inquiry (PS)
- Member/Patient Problem (PR)
- Notification of Pregnancy (PR)
- Other (PS)
- Provider Panel Question (PR)
- Provider Relations Visit Request (PR)
- Service Coordinator (SH)
- Transition Specialist (SH)
- Web Portal Issue (WEB)

Secure Messages



- **Success! Message Sent** will display at the top of the **Inbox** when the message has been sent.





User Management

User Management

- It is the responsibility of the Account Administrator to manage the accounts.
- You can access this feature by clicking **User Management** in the dropdown beside your name or by clicking **Manage Accounts**
- Using this feature you can **Verify Account/Update User** to disable and manage permissions for other users under the TINs in your account.

A screenshot of the Superior HealthPlan web application interface. The top navigation bar includes links for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. A dropdown menu is open next to the user's name, showing "Account Details" and "User Management" (highlighted with a red box). Below the navigation bar, there are fields for "Viewing Dashboard For: TIN" and "Plan Type" (Medicaid / CHIP), with a "GO" button. A red box highlights the "Manage Accounts" link in the right sidebar. The main content area includes a "Welcome" message, a "Quick Eligibility Check" section, and two sidebars: "Search for User" and "Invite a User". The "Search for User" sidebar contains fields for Email, Last Name, and Status, along with a "Verification Pending" checkbox and "Go!" and "Clear" buttons. The "Invite a User" sidebar contains an "Email Address" field, a "Send Invitation" button, and a link to the "Account Manager User Guide". At the bottom, there is a table with columns for Email Address, Last Name, First Name, TIN, Telephone Number, and Status. The table contains two rows, both with "Active" status. A red box highlights the "Verify Account / Update User" button in the right sidebar.

User Management



- To verify and activate new accounts, click on the orange button **Verify Account/Update User**.
- From this screen, authorized users can grant access and modify permissions for each user.
- Be sure to click on the **Verify Account** button once you modify permissions.
- Add notes and finish by clicking on the **Update User** button.

Email Address ↑	Last Name ↑	First Name ↑	TIN ↑	Telephone Number ↑	Status ↑	
laura.miller@superior.com	Miller	Laura	800000000	(207) 555-1234	Active	Verify Account / Update User
danielle.miller@superior.com	Miller	Danielle	800000000	(207) 555-1234	Active	

Update User status and permissions for Laura Miller

User Information

Email: laura.miller@superior.comStatus: **Active**
Name: Laura MillerLast Login Time: 2019-02-04 08:18:46
Telephone Number: (207) 555-1234

Profile Information

TIN: 800000000Verified: **No**

Can Access

☒ Claims☒ Assessments☐ Health Passport☐ Reports☒ Health Record☐ Manage Account☒ Eligibility

☒ Authorizations

Verify Account **Verify Account**

Update Status: ☐ Disable user

Comments: 200 characters left

Comments History:

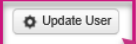
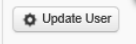
Verify User 1234567890101/30/2019 verified by admin Gloria Miller

User Management



- To disable or modify permissions for an existing user, select **Update User**.
- Make changes, add notes and finish by clicking on the **Update User** button.

danielle.brown@superior.com	Living	Danielle	RECENTLY	(201) 360-4001	Active	
danielle.brown@superior.com	Living	Shayla	RECENTLY	(201) 360-4001	Active	

Update User status and permissions for Shayla

User Information

Email: danielle.brown@superior.com Status: Active
Name: Shayla Last Login Time: 2019-01-18 09:22:59
Telephone Number: (201) 360-4001

Profile Information

TIN: Verified: Yes

Can Access

☐ Claims ☐ Assessments ☐ Health Passport ☐ Reports ☐ Health Record ☐ Manage Account ☒ Eligibility

☒ Authorizations

Update Status: ☐ Disable user

Comments: 200 characters left

Comments History: Verify User 01/18/2019 verified member info



Provider/Practitioner Info Management

Provider/Practitioner Information Management



- To confirm or update provider/practitioner information, go into **Account Details** and select your Primary TIN in the list.

The screenshot shows the Superior Healthplan provider dashboard. At the top, there is a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and Help. Below this, a dropdown menu is open, showing "Account Details" (highlighted with a red box) and "User Management". The main content area includes a "Quick Eligibility Check" section with input fields for "Member ID or Last Name" (containing "123456789 or Smith") and "Birthdate" (containing "mm/dd/yyyy"), and a "Check Eligibility" button. Below this is a "Recent Claims" section with a table header showing "STATUS", "RECEIVED DATE", "MEMBER NAME", and "CLAIM NO.". On the right side, there is a "Welcome" sidebar with links for "Add a TIN to My ACCOUNT", "Manage Accounts", and "Reports".

Provider/Practitioner Information Management



Provider/Practitioner Information Management (Tax Id: 2712894487) Confirm All

To begin, please select whether you would like to verify or update information on your Organizations and Locations or if you would like to update information about the Practitioners in your organization.

Associated Providers **Practitioners**

Medical Center (NPI:)

- To update provider/practitioner information, select your **Associated Provider** or **Practitioners** from the list and click **Edit** to begin.

Practitioner Y Thompson Adult Day C 10111 Business Highway 10, Dallas, TX 75243

Practice Details

SUNDAY	Closed
MONDAY	06:00 - 17:00
TUESDAY	06:00 - 17:00
WEDNESDAY	06:00 - 17:00
THURSDAY	06:00 - 17:00
FRIDAY	06:00 - 17:00
SATURDAY	Closed

Translation Services: ☐

Accessible to people with disabilities: ☒

What types of accessibility options do you offer?

Parking space curb ramps, loading zones at building entrance	☐
Doorways wide enough to ensure safe passage for mobility aids	☐
Wheelchair accessible restrooms with grab bars and accessible lavatories	☐
ASL signage and raised tactile text characters at office elevators and restrooms	☐
Medical equipment accessible to patients using mobility aids	☐
Exam rooms accessible to patients using mobility aids	☐

Edit Confirm

Provider/Practitioner Information Management



- From this screen, you can **update** the provider's/practitioner's physical address, phone numbers, office days and hours and accessibility details.

The screenshot shows a web form for managing provider information. The header includes the provider name "Felicidad Y Tranquilidad Adult Day C" and a date "02/17/2016 10:00:00 AM". The form is divided into several sections. The first section, "Felicidad Y Tranquilidad Adult Day C", contains input fields for "Address Line1", "Address Line2", "City", "State" (a dropdown menu currently showing "Texas"), "Zip Code", "Phone:", and "Fax:". To the right of these fields is a "Select All" checkbox and a "Practice Details" section. The "Practice Details" section lists the days of the week from "SUNDAY" to "SATURDAY", each with a checkbox and a time selection interface (HH:MM - HH:MM). Below the days are two buttons: "Closed" and "Open 24hrs". The second section, "Translation Services:", has a checkbox. The third section, "Accessible to people with disabilities:", has a checked checkbox. Below this is a box titled "What types of accessibility options do you offer?" containing a list of options with checkboxes: "Parking space curb ramps, loading zones at building entrance", "Doorways wide enough to ensure safe passage for mobility aids", "Wheelchair accessible restrooms with grab bars and accessible lavatories", "ASL signage and raised tactile text characters at office elevators and restrooms", "Medical equipment accessible to patients using mobility aids", and "Exam rooms accessible to patients using mobility aids". At the bottom right of the form are two buttons: "Update" (highlighted with a red box and a red arrow) and "Cancel".

Provider Relations



- Responsible for provider orientation and education:
 - Billing requirements.
 - New products, programs or processes.
- Liaison for claims issues or concerns.
- Provider Representatives offers online webinar trainings, in addition to local group training sessions. To view the updated training calendar, visit [Superior' Provider Training Calendar](#).
- To locate your local Provider Representative, visit [Find My Provider Representative](#) webpage.

Contact Information



Department	Contact	Phone/Fax
Provider Services	Claims Inquiry	1-877-391-5921
Medical Management	Prior Authorization	1-800-218-7508 / Fax: 1-800-690-7030
Secure Provider Portal	Support Team	1-866-895-8443
EDI Department	Support Team	1-800-225-2573, ext. 25525

**Please have Tax ID or NPI available.*

Claims Address

Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803

Claim Appeals Address

Superior HealthPlan
P.O. Box 3000
Farmington, MO 63640-3800

For more information and resources, visit us at SuperiorHealthPlan.com.



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Questions and Answers
