



### Grievance, Appeal, Concern or Recommendation Form

If you wish to file a grievance, appeal, concern or recommendation, please complete this form. If you choose not to complete this form, you may write a letter that includes the information requested below. The completed form or your letter should be mailed to:

Superior HealthPlan  
Appeal Department  
2100 South Interstate 35  
Suite 200  
Austin, TX 78704  
Phone 1-877-687-1196  
Relay TX/TTY 1-800-735-2989  
Fax 1-800-716-2036 (Appeal)  
Fax 1-800-310-0943 (Grievance/Complaint)

Member's Name: \_\_\_\_\_

Member's Ambetter #: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member Phone Number: \_\_\_\_\_

Tracking Number (if applicable. Found in upper left hand corner of denial letter):  
\_\_\_\_\_

Additional information to support the grievance, appeal, concern or recommendation (or attach):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Member or Representative: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

*\*You must file an appeal within 180 calendar days of the date of the denial letter.  
\*You must file a grievance within 180 calendar days of the date of the event.*