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
TDD/TTY 1-877-941-9237
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.

AMB16-TX-C-00048