PCOT
Physicians Contracting Organization of Texas

Committed to patient advocacy.
Quality healthcare. Independent physicians.

June 22, 2011

To All PCOT Practices

Ladies and Gentlemen:

On June 22, 2011, the PCOT's Board of Directors executed a contract with Superior Health Plan , Inc, a HMO network for Medicare Advantage and Medicaid managed plans. Please see the attached summary of terms of this contract. Our Provider Relations Representative is Tonya Prince and can be reached at 866-529-0294 ext 42278 or tprince@centene.com. This contract does not include well vision care or Behavior Health services. We are working with Superior for an additional contract for those services.

Please indicate your practice's plans to participate in this Superior contract by checking one of the boxes below for the health plan. This response should be mailed to PCOT, P.O. Box 132716, Tyler, Texas 75713 or faxed to 903-526-2320. **The Medicare Advantage Provisions Addendum must also be signed and returned if you chose to participate in the contract.**

Sincerely,

Brenda Shepherd

Brenda Shepherd, MBA, CPC,CPCS
Executive Director

_____ Yes, our practice will accept these fees and all physicians in the practice will participate in the Superior contract for Medicare Advantage

_____ No, our practice does not wish to participate in the Superior contract for Medicare Advantage.

_____ Yes, our practice will accept these fees and all physicians in the practice will participate in the Superior contract for Managed Medicaid.

_____ No, our practice does not wish to participate in the Superior contract for Managed Medicaid.

Date:_____ Practice Name:_____

Authorized Signature:_____

Tax I.D. No._____

Printed Physician Name(s)

1318 Doctors Drive Tyler, TX 75701
903-526-3268 or 1-888-248-1907 Fax: 903-526-2320
info@pcot.org www.pcot.org

MEDICARE ADVANTAGE PROVISIONS ADDENDUM

References to "**Provider**" in this Medicare Advantage Provisions Addendum ("**Addendum**") are to the provider of health care services contracted with [INSERT ENTITY'S NAME] under a participation agreement ("**Agreement**"). [INSERT ENTITY'S NAME] has entered into an agreement ("**MAO Agreement**") with one of more health care entities ("**MAO**") who have an agreement with the Centers for Medicare and Medicaid Services ("**CMS**") for the provision of medical and related health care services to Medicare Advantage beneficiaries ("**Members**"). The following provisions relate specifically to services provided by Provider to an MAO and its Members. In the event of a conflict between the terms of this Addendum and the Agreement with respect to Medicare Advantage, the terms of this Addendum control.

a) **Provider** agrees to: (i) abide by all federal and state laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information, (ii) ensure that medical information is released only in accordance with applicable state or federal law, or pursuant to court orders or subpoenas, (iii) maintain all Member records and information in an accurate and timely manner, and (iv) allow timely access by Members to the records and information that pertain to them.

b) Provided the MAO is responsible for the payment of claims directly to **Provider, Provider** agrees that the MAO will process all claims for Covered Services which are accurate and complete within thirty (30) days from the date of receipt.

c) **Provider** agrees that in no event, including, but not limited to, nonpayment by the MAO, the MAO's insolvency or breach of the Agreement, shall **Provider** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than the MAO (or the payor issuing the health benefits contract administered by the MAO) for Covered Services provided by **Provider** for which payment is the legal obligation of the MAO. This provision shall not prohibit collection by **Provider** from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member health benefits contract. **Provider** further agrees that: (i) this provision shall survive the expiration or termination of the Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Provider** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees and contractors of **Provider**, if any, who are providing services to Members.

d) **Provider** agrees that nothing in the Agreement shall be construed as relieving the MAO of its responsibility for performance of duties agreed to through its Medicare Advantage contracts existing now or entered into in the future with CMS.

e) **Provider** agrees to comply with and be subject to all applicable Medicare program laws, rules and regulations, reporting requirements, and CMS instructions as implemented and amended by CMS. This includes, without limitation, HHS', the Comptroller General's or their designees right to evaluate, inspect and audit **Provider's** operations, books, records, and other documentation and pertinent information related to **Provider's** obligations under the Agreement. **Provider** further agrees HHS', the Comptroller General's, or their designees right to inspect, evaluate and audit any pertinent information for any particular contract period will exist through ten (10) years from the final date of the contract period between the MAO and CMS or from the date of completion of any audit, whichever is later, and agrees to cooperate, assist and provide information as requested by such entities.

f) **Provider** agrees to retain all contracts, books, documents, papers and other records related to the provision of services to Medicare Advantage Members and/or as related to **Provider's** obligations under the Agreement for a period of not less than ten (10) years from: (i) the end of the contract period between the MAO and CMS; or (ii) from the date of completion of any audit, whichever is later.

g) **Provider** agrees to comply with the MAO's policies and procedures.

h) **Provider** agrees to immediately notify the MAO if he/she/it is excluded from participation in Medicare.

i) **Provider** agrees that in the event of the MAO's insolvency or termination of the MAO's contract with CMS, benefits to Members will continue through the period for which premium has been paid and benefits to Members confined in an inpatient facility will continue until their discharge.

j) In the event **Provider** is required to submit claims or other data to the MAO, the submission shall include a certification from **Provider** that such data is accurate, complete and truthful.

k) With respect to any Members who are eligible for both Medicare and Medicaid, **Provider** agrees that such Members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, with respect to such Members, **Provider** agrees to: (i) accept the payment amount from the MAO as payment in full, or (ii) bill the appropriate State source.

The parties agree this Addendum is effective upon execution.

[INSERT ENTITY'S NAME]:

Name: _____

Print Name: _____

Date: _____

Provider:

Name: _____

Print Name: _____

Date: _____

		Physicians Contracting Organization of Texas	
		Contract Review Worksheet	
		BLS 5-12-2011	
		Background Information	
	1	Payor Name, Organizational Status	**Superior Health Plan HMO**
	2	Type of Organization	HMO Medicare Advantage; Managed Medicaid and CHIP
	3	Type Product	Medicare Replacement; Managed Medicaid/CHIP
	4	Background Due Diligence, OIG Exclusion, TDI	no reports
	5	Number of covered lives, major employers	425,392 in Texas
	6	Hospital affiliations	ETMC; Titus
	7	Laboratory affiliations	Lab Corp; Quest
	8	Benefit plan description (Covered Services defined)	Medicare /Medicaid
	9	Provider procedure manual	superiorhealthplan.com
	10	References/ Notes	Must notify Superior with a 45 day written notice if planning to close practice to new patients
			Plan has a formulary with Caremark
			Must notify covered person of the cost of non-covered services prior to rendering services and obtain a signed statement
		Formulary	txvendordrug.com/downloads/pdl/txpdl_012011.pdf
		Terms	
**	11	PCOT Agency Status defined	yes Art III, #1; Art XI #1
	12	Each party responsible for their own acts	yes
		Hold Harmless and Indemnification language	yes; Art VIII Section # 1 and #2
		Arbitration & mediation non binding	Binding; Art IX #2; Agreed to Non-Binding with amendment
**	13	No assignment without consent (Silent PPO)	Amend to not allow assignment by IPA or HMO without prior written consent; Art XI, #3; amended to add notification with 60 days
	14	No all products clauses	
	15	No marketing w/o consent	
**	16	Credentialing delegated	yes; attachment
**	17	Members can not be terminated w/o cause	90 days written notice; Art X #2G; Suggest after all appeals/discretion of HMO and IPA; Art X #3 allows HMO to selec /reject members at their discretion; agreed to appeal process prior to term
**	18	Adequate grievance process	yes
	19	Modifications must be mutually accepted	Art XI #7; IPA must object within 30 days of notice of amendment/ amended to 60 days
**	20	Access and confidentiality reasonable	yes
	21	Members may charge for requested medical records	no suggest amendment; amended to follow TMB Guidelines
	22	Governed by Texas Law, govered in county where care was recd	Follows Federal and State Laws; Art XI #5
**	23	Max liability insurance required 200,000/ 600,000	yes: $100/$300 minimum; Art VII #1
**	24	Term: 1 year max	3 years; Art X; #1; amended to one year term
	25	Auto renewal	yes for one year periods; Art X #1
**	26	Termination w/o cause not > 90 days	180 days; suggest 90 days; Art X #2A; amended to 90 days
	27	Termination Tail reasonable	
	28	HIPAA language--code sets	Yes Art IV #2
		Billing/ Compensation	
	29	Claims processor (payor) identified	MC/MC
**	30	Claims paid < 30 days (or comply with SB 418)	Attachment A

	31	Penalty for non timely payment (Predetermined)	Attachment C; follow CMS Guidelines
	32	Payment to Non-Physician Providers	
	33	Standard filing form (HCFA 1500) acceptable; electronic	Attachment A
	34	Right to coordination of benefits payments	Attachment A
	35	Retroactive adjustments within 90 days	Not stated; follow State law of 180 days; Must follow CMS for Medicare; Medicaid is 180 days
	36	Enrollee identification process specified	yes; ID card with Network ID
**	37	Complete fee schedule	Medicare - 100% of current year schedule; Medicaid - 100% of current year schedule; agreed to add all ancillary members except Ods and BH
		Non Specified	Not to exceed 100% of Medicare
		Meets PCOT Minimum Criteria	
	38	Fee schedule fixed for contract period	follow Medicare and Medicaid updates quarterly
	39	Fee schedule review & increase at renewal (auto escala	No
	40	New CPT Code Changes/Updates effective January 1st	No; within 45 days after payor notification of State acceptance of changes and effective date as determined by the State- Exhibit 1 #16; amended to follow CMS
		The Provider Relations Representative is Tonya Prince at 866-529-0294 ext 42278 tprince@centene.com	
		Miscellaneous Comments/Notes	
		Carved Out Care- Well Eye Care to OptiCare	
		Carved Out Care- Behavorial Health to Integrated Mental Health Services	

SUPERIOR HEALTHPLAN

SUPERIOR HEALTHPLAN **ATTACHMENT B**

SUPERIOR HEALTHPLAN KIDS

ADDRESSES

El Paso/Amarillo Office
6070 Gateway East, Suite 400
El Paso, Texas 79905
877-391-5923 Toll Free
915-778-7475 Local

San Antonio Office
8431 Fredericksburg Rd, Ste 340
San Antonio, Texas 78229
866-615-9399 Toll Free
210-562-2700 Local

IMHS Behavioral Claims
P.O. Box 6300
Farmington, MO 63640-6300

Austin Office
2100 South IH 35, Ste. 202
Austin, Texas 78704
800-218-7453 Toll Free
512-692-1465 Local

Corpus Christi Office
5350 So. Staples Ste. 225
Corpus Christi, Texas 78411
800-656-4817 Toll Free
361-994-5600 Local

Claims Department
P.O. Box 3003
Farmington, MO 63640-3803

Claims Appeals Department
P.O. Box 3000
Farmington, MO 63640-3800

Lubbock Office
7202 Slide Rd. Ste. 202
Lubbock, Texas 79424
806-698-0267 Local

DEPARTMENTS

Provider Services

(Claim Issues/Status)
STAR , STAR+PLUS, Medicare, CHIP/CHIP PERINATE

877-391-5921 Option 3

RSA and RSA CHIP Perinate
800-522-8923

Medical Management

(Referrals & Authorizations)

800-218-7508

800-690-7030 Fax

Or: request on Superior's Web Portal
www.superiorhealthplan.com

Member Services (Benefits, Eligibility, Member Advocate, Outreach)
STAR ,CHIP, PERINATE
800-783-5386

RSA
800-820-5685
STAR+PLUS
866-516-4501

Behavioral Health Provider
Integrated Mental Health
800-716-5650 (Star)
800-466-4089 (Star+Plus)
888-471-4357 (Chip)
800-213-9927 (Chip RSA)
877-730-2117 (Claims Inquiries)
866-218-8263 (STAR Health)

Routine Vision Services Provider
AECC/Total Vision Health Plan
888-756-8768 (Star)
800-360-9165 (Chip)
800-360-8768 (Chip EPO)
866-897-4785 (Provider Line)

Nursewise	Dental Services Provider	EDI Department
(24 hours Nurse Service) 800-783-5386 Option 7	**CHIP-Delta Dental** 866-561-5892 **STAR+PLUS- Delta Dental -866-512-8259**	(Electronic Submissions) 800-225-2573 (ext 25525)

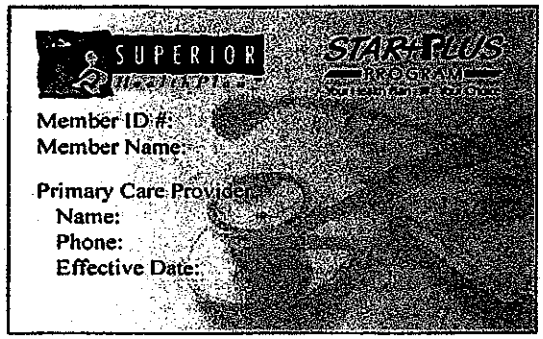
WEBSITE INFORMATION

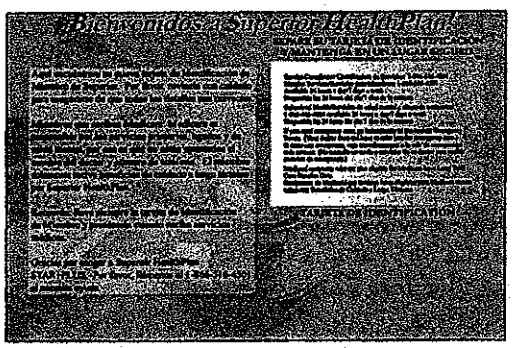
We also encourage you to visit our website at **www.superiorhealthplan.com.**
Log on to the website to access Superior's on-line eligibility verification and claims status checks.

OTHER IMPORTANT NUMBERS	
HHSC - Office of Investigations (Medicaid Fraud)	800-436-6184
HHSC Provider Resolutions - CHIP and Medicaid	512-338-6569
Maximus (Star Help Line)	800-964-2777
Medical Transportation Program (Star)	877-633-8747
STAR Automated Inquiry System (AIS)	800-925-9126
TMHP Inquiries Line	800-925-9126
Vendor Drug Program (PROVIDER ONLY LINE for STAR and CHIP)	800-435-4165
Texas True Choice (Contracting/Credentialing)	800-683-4856

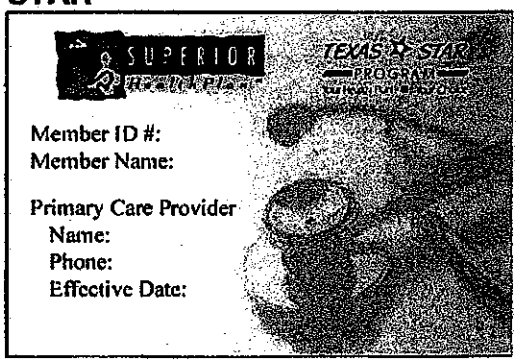
ATTACHMENT E

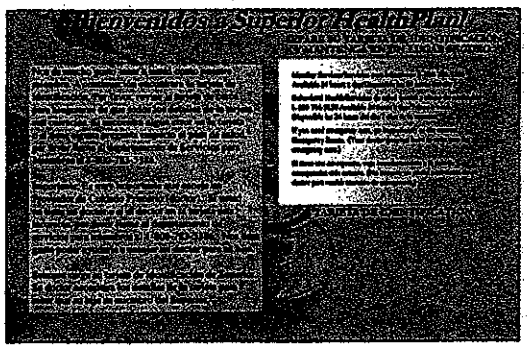
STAR+PLUS



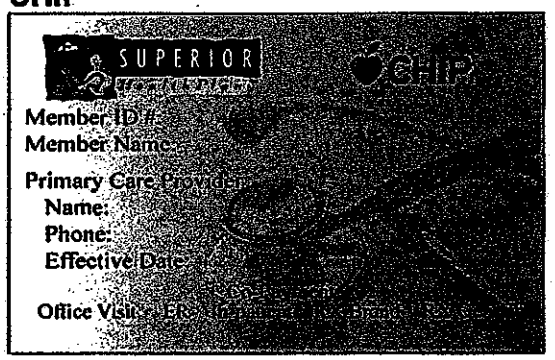


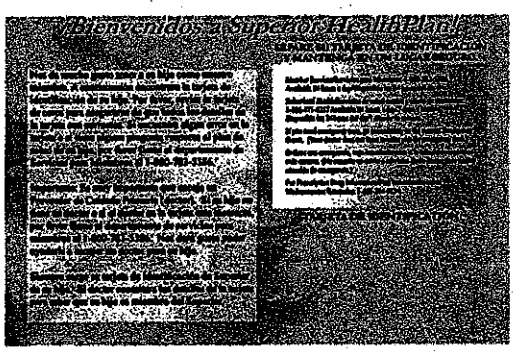
STAR





CHIP





SUPERIOR HealthPlan®

Effective 08/02/2010

Phone: 1-800-218-7508 www.superiorhealthplan.com FAX: 1-800-690-7030

Superior HealthPlan requires that all services described on this list be authorized prior to the services being rendered. Requests should be submitted no less than **5 business days prior** to the start of service. All services are subject to eligibility at the time of service and benefit limitations or exclusions.

Inpatient Hospitalization:

Pre-scheduled, elective admissions must have authorization prior to admission. Fax the request along with clinical to 1-800-690-7030.

Emergent inpatient admissions to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admission, and all other inpatient facility type require notification by the close of the next business day. Notification may be completed by contacting one of the numbers below:

San Antonio Region fax 877-650-6942, phone 866-615-9399
Corpus Christi Region fax 877-650-6940, phone 800-656-4817
El Paso/Lubbock/Amarillo Region fax 877-650-6941, phone 877-391-5923
Austin Region fax 877-650-6939, phone 800-218-7453 X 22026 or 22175
If unsure where to call or fax, call the Prior Auth Hotline at 1-800-218-7508 for assistance.

Non-Participating/Out of Network Providers:

Request for services from a non-participating, out of network facility, provider, or vendor in any location requires authorization. **Except in the case of emergent admissions. The notification process above should be followed.**

Services Requiring Auth

Specialists
- Chiropractor
- Oral Surgeon*
- Plastic and Reconstructive Surgery*
- Podiatry*
- Pain management *

*NOTE: Office visits do not require authorization; only procedures performed in any location require authorization

In Home/Outpatient Therapy/Rehabilitation
excludes initial and re-evaluation. Physician signature on treatment plan required
- Cardiac Rehab
- Occupational*
- Physical*
- Pulmonary Rehab
- Speech*

*NOTE: Therapy provided by an ECI provider as part of an ECI IFSP are excluded from authorization requirement

Other Services and Tests
- DME over $500 purchase price each item
- Home Health/Skilled Nursing/Private-Duty Nursing
- Orthotics over $500 purchase price each item
- Prosthetics over $500 purchase price each item
- Hearing Aids for Medicaid adults 21 and over
- Nutritional Counseling (no authorization when performed as part of a THSteps exam or for ECI assessment)
- Sleep Study
- OB ultrasounds-limited to 3 ultrasounds for non-high risk pregnancy without authorization; no authorization required for high-risk pregnancy ultrasounds

Surgical or Other Procedures
- Abortion
- Bariatric Surgery
- Blepharoplasty
- Circumcision 1 year and older
- Implantable devices including Cochlear Implant
- Mammoplasty
- Otoplasty
- Rhinoplasty/Septoplasty
- Scar Revision/Excision of lesion
- Treatment of Varicose Veins
- Vagus Nerve Stimulation

Long Term Services & Support (LTSS)
- Personal Attendant Services (PAS)
- Day Activity & Health Services (DAHS)

STAR+PLUS Waiver Services:
- Personal Attendant Services (PAS)
- Day Activity & Health Services (DAHS)
- Nursing Services (In home)
- Emergency Response Services (ERS)
- Home Delivered Meals (HDM)
- Minor Home Modifications (MHM)
- Assisted Living (AL)
- Transition Assistance Services (TAS)
- Adult Foster Care (AFC)

Transportation
- Air transport
- Non-emergent ambulance-including facility to facility transport

Pharmaceuticals:
Injectibles over $100 administered in any outpatient setting
Excludes: Chemotherapy Drugs J9000-J9999 (unless prescribed for off label use), Epogen/Aranesp for ESRD on Dialysis J0882 and J0886, Epogen and Neupogen for oncology J0881. J0885, J1440, J1441.
Oncology drugs when utilized for off label purposes require authorization

Transplant:
All services for Transplant Evaluation and Transplant Procedure

Radiology
Precertification through NIA, Inc. is required for outpatient diagnostic procedures
- CT
- CTA
- MRI
- MRA
- PET

Contact NIA at 1-800-218-7508 opt 3 or visit www.radmd.com

All authorization requirements for SSI Members in the El Paso & Lubbock Service Areas will follow the guidelines according to the Texas Medicaid Provider Procedures Manual

Covering Providers
PCPs and Specialty Care Providers must arrange for coverage with another Superior network Provider during scheduled or unscheduled time off. In the event of unscheduled time off, please notify the Provider Relations Department of coverage arrangements. Covering providers must have an active National Provider Identifier number in order to receive payment. For provision of services to Medicaid Members, providers must also have an active Texas Provider Identifier (TPI).

Verification of Member Eligibility

Providers should verify Member eligibility prior to delivering service at each visit. Providers can verify eligibility by:

- Accessing Superior's Provider Website at www.superiorhealthplan.com. (Note: This website is updated upon receipt of information from the State and eligibility may change (i.e. be retro activated or terminated). As a result, eligibility verification from the website does not guarantee payment.
- Member's Medicaid 3087 Form
- Members Superior HealthPlan ID card (please call Member Services for up-to-date eligibility information)
- Contacting Superior Member Services at:
    - STAR, CHIP HMO/Perinate 800-783-5386
    - STAR+PLUS 866-516-4501
    - CHIP RSA/Perinate 800-820-5685
    - STAR Health 866-912-6283

In addition, the State provides mechanisms to verify eligibility for any STAR, STAR+PLUS, CHIP HMO, CHIP Perinate, STAR Health or CHIP RSA.

For STAR /STAR+PLUS:

- Medicaid 3087 Form
- Temporary Medicaid form 1027A
- State Automated Inquiry System (AIS) 800-925-9126

For CHIP & CHIP Perinate

- CHIP Inquiry System 800-645-7164
- CHIP Customer Service 800-647-6558

For STAR Health

- DFPS 2085 Form
- Member's Medicaid 3087 Form
- Medicaid 1027-A Form (only issued to assist with pharmacy issues)
- Members Superior HealthPlan Network ID card (please call Member Services for up-to- date eligibility information)
- Contacting Superior Member Services at **866-912-6283**

- Provider directories

Provider Relations

- Contracting questions and inquiries
- Provider orientations both in person and via the web, for all products and special SHP offered programs
- Provider education on claims, billing, Texas Health Steps, or any other issue related to Superior Health Plan services
- Provider updates/demographic changes

NurseWise®

- 365 days a year/24hours a day/7 days a week call center available for Providers or Members.
- Staffed by nurses and customer service staff who are fluent in both English and Spanish
- Answer Member health questions
- Verify eligibility

Quick Reference Guide Phone List

Below is a listing of Superior and State Program contacts.

Superior HealthPlan Contacts	Telephone #
Claims Inquiries/Status	877-391-5921 Opt 3
Provider Complaints	800-783-5386
Credentialing	800-826-5686, Ext 22201
Medical Management (Referrals/Authorizations)	800-210-7508
Medical Management FAX NUMBER (Referrals/Authorizations)	800-690-7030
STAR, CHIP, HMO Member Services	800-783-5386
STAR+PLUS Member Services	866-516-4501
CHIP-A Member Services	800-820-5685
Nurse Advice Line – NurseWise ®	800-783-5386 Opt 7
Superior El Paso Office (including Lubbock/Amarillo)	877-391-5921 915-778-7968 (Local)
Superior San Antonio Office	866-615-9399 210-615-9399 (Local)
Superior Austin Office	800-218-7455 512-502-7455 (Local)
Superior Corpus Christi Office	800-656-4817 361-994-5600 (Local)
Superior Dallas Office	866-534-5949
Superior Houston Office	866-534-5946
Superior HealthPlan – State Contacts	**Telephone #/Email**
DHP Provider and Policy Line	800-647-7538
HHSC – Office of Inspector General (Medicaid Fraud)	800-436-6184

Superior HealthPlan Contacts	Telephone #
HHSC Provider Resolution – CHIP and Medicaid	HPM_complaints@hhsc.state.tx.us
HHSC Provider Resolution – STAR Health	star.health@hhsc.state.tx.us
HHSC Austin Texas Health Steps Regional Office	512-873-5300
HHSC El Paso Texas Health Steps Regional Office	915-834-7675
HHSC San Antonio Texas Health Steps Regional Office	210-949-2000
Texas Access Alliance (STAR Help Line)	800-964-2777
Medical Transportation Program (STAR)	877-633-8747
STAR/STAR+PLUS Automated Inquiry System (AIS)	800-925-9126
STAR SSI Claims Administrator	800-925-9126
Texas Medicaid/CHIP Prescription Help Desk	800-435-4166
Medicaid Eligibility and Help Line	800-964-2777

Superior Subcontractors

Superior HealthPlan subcontracts with qualified companies for the provision of specialized services to our Members.

Superior HealthPlan – Subcontractors	Telephone #
STAR Behavioral Health – Integrated Mental Health Service (IMHS)	800-716-5650
STAR+PLUS Behavioral Health – Integrated Mental Health Service (IMHS)	800-466-4089
Nurse Advice Line – NurseWise ®	800-783-5386 Opt 7
CHIP HMO Behavioral Health – Integrated Mental Health Service (IMHS)	888-471-4357
Vision – AEC/Total Vision Health Plan: All Products	800-360-4768
Delta Dental Provider Relations	866-287-3252
DeltaDental Member Services	866-287-3419
Nurtur Disease Management	214-576-2082

Request for Prior Authorization

SUPERIOR

Date of request * ___ / ___ / ____

*Required items. Please write only in designated areas.

Member Information

Member ID*

Date of Birth* ___ / ___ / ____

Last Name

First Name

Provider to Perform the Service

NPI*

TPI*

Taxonomy

Tax ID*

Last Name, First Initial or Facility Name

Fax Number* ___ - ___ - ____

Contact Number* ___ - ___ - ____

Contact Name / Requestor

Submitting / Referring Provider

☐ **'X' in box if same as above.**

NPI*

Last Name, First Initial or Facility Name

Fax Number* ___ - ___ - ____

Contact Number* ___ - ___ - ____

Contact Name / Requestor

Requested Service

Type of Service*:

- ☐ DME rental ☐ DME purchase *(requires signed physician's order)*
- ☐ Home Health *(Require signed physician's order and plan of care/treatment plan)*
- ☐ Office Visit
- ☐ Outpatient Services
- ☐ Rehab *(Require signed physician's order and plan of care/treatment plan)*
- ☐ Inpatient
- ☐ Other ______________

LTSS Services:

- ☐ PAS
- ☐ DAHS
- ☐ ERS
- ☐ Home delivered meals
- ☐ Med Box Refills
- ☐ Other ______________

Place of Service*:

- ☐ Office
- ☐ Outpatient Hospital/ASC
- ☐ Home
- ☐ Outpatient Clinic
- ☐ Outpatient Rehab
- ☐ Inpatient
- ☐ Other ______________

Clinical Review

Procedure codes:

Procedure code/CPT,HCPCS* modifier

Procedure code/CPT,HCPCS* modifier

Procedure code/CPT,HCPCS* modifier

Service Description:

Diagnosis:

Referring Diagnosis Code*

Referring Diagnosis Code

Start Date* ___ / ___ / ____

End Date* ___ / ___ / ____

Units/Visits* X ☐ **Day** ☐ **Week** ☐ **Month**

☐ ***'X' indicates clinicals or plan of care attached.***

Contact Information

Fax Numbers:

LTSS Bexar:	866-224-8254
LTSS Nueces:	866-703-0903
Admissions	888-886-0170
Referrals:	800-690-7030
Hotline:	800-218-7508

☐ Urgent Request - By checking this box, I certify that this is an urgent request for medically necessary treatment, which must be treated within 24 hours.

____
Signature of Requesting Physician (required)

Superior requires that certain services be approved before the service is rendered. Please refer to the SHP website, www.superiorhealthplan.com for the most current full listing of authorized procedures and services. Note that an authorization is not a guarantee of payment and is subject to utilization management review, benefits and eligibility.

For office use only

Authorization number: ______________

Units: ______________

Dates authorized: ______________

03/31/10

B.45 Private Pay Agreement

I understand _____(Provider Name)_____ is accepting me as a private pay patient for the period of _____, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: _____

Date: _____

B

CLAIMS APPEAL FORM

Mail completed Claims Appeal Form to:
Superior HealthPlan
Provider Appeal Coordinator
P.O. Box 3000
Farmington, MO 63640

Provider Name	**Texas Medicaid Provider Number**
Claim Control Number	**Date(s) of Service**
Member Name	**Member Number**

Reason for Appeal:

☐ Other insurance payment (EOB; EOP must be attached)

☐ Incorrect payment or other (please explain below)

Comments:

Do not complete the shaded areas:

Date Received	Date By	Reviewed By

CORRECTED CLAIM

Mail completed form to:
Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803

Provider Name	**Texas Medicaid Provider Number**
Claim Control Number	**Date(s) of Services**
Member Name	**Member Number**

Reason for request:

☐ Other insurance payment (EOB; EOP must be attached)

☐ Incorrect payment or other (please explain below)

Comments:

Do not complete the shaded areas:

Date Received	**Date Due**	**Reviewed By**

SUPERIOR HealthPlan

Request for Claim Status

Phone:(877) 391-5921 option 3
Fax: (866) 461-9462

Date* ☐☐/ ☐☐/ ☐☐☐☐

Contact First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Contact Number ☐☐☐ - ☐☐☐ - ☐☐☐☐ EXT. ☐☐☐☐

Provider Tax ID ☐☐☐☐☐☐☐☐☐

Fax Number ☐☐☐ - ☐☐☐ - ☐☐☐☐

* Required Information. Please do not write in the grey areas.

Provider Name*	Member Name*	Member ID Number *	Date of Service *	Billed Amount	For Superior HealthPlan Use Only: Amount Paid	Check #	Status

Please allow five (5) buisness days for Superior HealthPlan to review and return request for Claim Status.