Corrected Claim Form

Please mail completed form to:

Allwell from Superior HealthPlan
ATTN: Corrections, Reconsiderations or Appeals
PO Box 3060
Farmington, MO 63640-3822

Provider Name	**Medicare Number and/or NPI 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**