Member Complaint Form

Complete and mail or fax to:
5900 E. Ben White Blvd. | Austin, Texas | 78741 | Fax: 1-866-683-5369

Member's Name:_____ **Medicaid or CHIP ID Number:**_____

Relationship to Member (please circle one): Self Parent Legal Guardian Spouse
Other:_____

Phone Number:_____

Street Address:_____

City:_____ **State:**_____ **Zip:**_____ **County:**_____

Complaint type (please choose one):
❑Accessibility/Availability of Service (Location not convenient and/or hard to find appointment times)
❑Attitude or Service of Superior Employees
❑Balance Billing
❑Case Management
❑Complaint Process
❑Marketing
❑Pharmacy
❑ID Cards
❑Language or Interpreter Services
❑Quality of Care
❑Quality of Office Site (Physical appearance of office and/or long wait time)
❑Quality of Service at Doctor's Office
❑Transportation
❑Other

Complaint Details

What is your complaint?

How can Superior resolve your issue?

For Administrative Use Only
Complaint No.:_____ Date Received: