Humana®

GRIEVANCE/APPEAL REQUEST FORM

Please complete the form with information about the member whose treatment is the subject of the grievance/appeal.

Member Name:	
Member ID #:	Date of Birth:
Authorized Representative*:	
Phone Number:	
Address:	

Service or Claim Number
Provider Name
Date of Service

Please explain your grievance, appeal, or complaint and your expected resolution. Attach extra pages if you need more space.

* We must have an Appointment of Authorized Representative (AOR) form or other legal documentation when a request for a grievance and/or appeal is submitted by someone other than the member. If this form or other legal documentation is not on file, we are unable to continue your appeal or grievance.

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Member (or Representative) signature

Date

Relationship to Member (if Representative)

Important: Return this form to the following address for prompt resolution of your grievance or appeal:

Humana Inc.
Grievance and Appeal Department
P.O. Box 14165
Lexington, KY 40512-4165

Humana is a Medicare Advantage organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

This information is available for free in other languages. Please call our customer service number at 1-800-457-4708. If you use a TTY, call 711. Our hours are 8 a.m. to 8 p.m. Monday – Friday.

Esta información está disponible gratis en otros formatos o idiomas. Contacte por favor nuestro número de servicio de atención al cliente al 1-800-457-4708. Si utiliza un TTY, llama al 711. Nuestro horario es de 8:00 AM a 8:00 PM de lunes a viernes.