APPEAL REQUEST FORM

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

Member name:	<member name>		
Member ID number:	<member ID number>	Date of birth:	<member date of birth>
Authorized Representative*:			
Phone Number:			
Address:			

Service or Claim number:	
Provider name:	
Date of service:	

Please explain your appeal 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. If you have any questions about this, please contact us at <customer service phone number>.

GHHKGGXEN

GRIEVANCE/APPEAL REQUEST FORM

______________________________________ ______________________________
Member (or Representative) signature Date

____
Relationship to member (if Representative)

Important: Return this form to the following address so that we can process your grievance or appeal:

Humana Inc.
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-800-949-2961