Appeal Request Form

If you have a complaint or grievance, please complete and submit this form to Humana to start the appeals process. Humana must receive the complete form **within 60 days of** the event you are appealing.

Failure to complete and return this form within 60 days can result in dismissal or denial of your appeal.

Please provide all requested facts and explain the problem/issue in detail. Include the name(s) of any Humana people you have dealt with and the dates on which specific events occurred. Use more paper if needed. Attach copies of any supporting documents you would like for us to consider.

Member information	
Member name:	Member ID:
Member mailing address:	
City, State, ZIP code:	
Phone number:	Email address:
Date of triggering event:	
Member's guardian (if applicable):	
Guardian phone number:	

Approved representative (if any)

I, ______________________________ approve ______________________________ to serve as my representative in connection with the appeal. I approve my representative to present proof, obtain facts about my appeal, and receive notices about my appeal. I know that my personal health information (PHI) may be disclosed to my representative. I know that my PHI may include facts about drug or alcohol disorders or treatment, mental health disorders or treatment, and contagious or non-contagious diseases. By signing this form, I am approving the release of this information. My representative will be free to act for me on the date and time of the appeal hearing set by Humana. I do not have a legally appointed guardian, or my legally appointed guardian hereby consents to this consent.

______________________________ Member signature

______________________________ Date

Humana
Healthy Horizons®
in Oklahoma

Please tell us about your request in the space below. Be as detailed as you can and provide any date(s) that you can. Please include what you would like Humana to do about this issue. (If you need more space, use another sheet of paper.)

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Important notice for members of SoonerSelect whose benefits or service were stopped or reduced:

You must request an appeal and your appeal must be received by Humana. Your appeal must be filed within 60 calendar days of the date of your notice. You can ask for your services to continue while your appeal is reviewed. You must ask for services to be continued within 10 calendar days of the date of your notice. You can also ask for your services to stop while your appeal is reviewed. If you file for an appeal within 60 calendar days of the date of your notice and do not ask for your services to stop, they will be continued during the review period. When your appeal doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.

If you do **not** want services or benefits to continue while your appeal is pending, check the box below:

☐ I **do not** want services or benefits to continue while my appeal is being decided.

______________________________ Member signature

______________________________ Date

Please send this form to:

Humana
Attn: Grievance and Appeals Department
P.O. Box 14359
Lexington, KY 40512-4359

Phone: **855-223-9868 (TTY: 711)**
Fax: 800-949-2961

Call If You Need Us

If you have questions or need help reading or understanding this document, call us at **855-223-9868 (TTY: 711)**. We are available Monday through Friday,

from 8 a.m. to 5 p.m., Central time. We can help you at no cost to you. We can explain the document in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Member Handbook regarding your rights.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, ethnicity, marital status, religion, or language. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

You may file a complaint, also known as a grievance:

Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.

If you need help filing a grievance, call **855-223-9868** or if you use a **TTY**, call **711**.

You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, **Office for Civil Rights** electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department**

of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/sites/default/files/ocr-cr-complaint- form-package.pdf**.

Auxiliary aids and services, free of charge, are available to you.

855-223-9868 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Humana Healthy Horizons in Oklahoma is a Medicaid product of Humana Wisconsin Health Organization Insurance Corporation.

Language assistance services, free of charge, are available to you.

855-223-9868 (TTY: 711)

English Call the number above to receive free language assistance services.

Español (Spanish) Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

Tiếng Việt (Vietnamese) Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

繁體中文 **(Chinese)** 您可以撥打上面的電話號碼以獲得免費的語言協助服務。

한국어 **(Korean)** 무료 언어 지원 서비스를 받으려면 위 번호로 전화하십시오.

Deutsch (German) Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

العربية:(Arabic) اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية .

မြ�န်�ာနို�ငံ (Burmese) အခမဲ့� ဘာသာစကား�ာ အကူအညီဝန်ဆော�ာင်မှုမဲ့�ာ ရယူရန် အထက်ပါ ဖုန်�န်ပါတ်ကို ဆက်�ပါ။

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

Tagalog (Tagalog – Filipino) Tawagan ang numero sa itaas para makatanggap ng mga libreng serbisyo sa tulong sa wika.

Français (French) Appelez le numéro ci-dessus pour recevoir des services gratuits d’assistance linguistique.

ພາສາລາວ (Lao): ໂທຫາເບີ ໂທລະສັບ ບີຂ້າງເທິງ ໆ ພື່�ອຮັບ ບໍລິການ ຊ່�ວຍເຫຼືອດ້ານພາສາຟຣີ .

ภาษาไทย (Thai): โทรไปท�่หมายเลขด้านบนเพื่�่อรบบริการช่วยเหล่อด้านภาษาฟร่

اردو(Urdu)- مفت لسانی اعانت کی خدمات موصول کرنے کے لیے درج بالا نمبر پر کال کریں

tsalagi gawonihisdi (Cherokee) ᎳᏴᏓᏏ ᎾᏍᎩ ᎦᏗᏔᏗᏟ ᏗᏎᏍᏓ ᎾᎢ ᎠᏎᏊ ᎦᏬᏂᎯᏍᏗ ᎤᎾᏓᏡᎬᏍᏗ ᎢᏣᎾᏓᏛᏁᏗᎢ.

فارسی(Farsi) . برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید