

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

Representative signature

Date

Representative Information

Representative mailing address:

City, state, ZIP code:

Phone number:

Email address:

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.)

Important notice for members of SoonerSelect whose benefits or services 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.

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 14163
Lexington, KY 40512-4163



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

