

**GRIEVANCE AND APPEAL REQUEST FORM**

Please complete this form with information about the Enrollee whose treatment is the subject of the grievance or appeal.

Enrollee name:	
Enrollee ID number:	Date of birth:
Authorized Representative*:	
Phone Number:	
Address:	
_____	
_____	

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

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

\_\_\_\_\_ Date

Enrollee (or Representative) signature

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Relationship to Enrollee (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: 1-833-660-0266

**Call If You Need Us**

If you have questions or need help reading or understanding this letter, call us at **1-866-432-0001** or **TTY**, call **711**. We are available Monday – Friday, from 8 a.m. to 6 p.m. Eastern time. We can help you at no cost to you. We can explain the letter in English or in your first language. We can also help you if you need help seeing or hearing. Please refer to your Enrollee Handbook regarding your rights.

**Discrimination is Against the Law**

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. See our website for more information.

Humana Inc. and its subsidiaries:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Enrollee Services at 1-866-432-0001 (TTY: 711).

If you believe that Humana Inc. or its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

## **Discrimination Grievances**

P.O. Box 14618  
Lexington, KY 40512-4618  
1-877-233-4816 or if you use a TTY, call 711.

You can file a grievance by mail or phone. If you need help filing a grievance, Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services (HHS), Office for Civil Rights electronically through the [Office for Civil Rights Complaint Portal](#), or by mail or phone at:

### **U.S. Department of Health and Human Services (HHS)**

200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)  
Complaint forms are available online at the [HHS Office for Civil Rights website](#).

Humana Healthy Horizons in South Carolina is a Medicaid Product of Humana Benefit Plan of South Carolina, Inc.

## **Multi-Language Interpreter Services**

**English** ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call **1-866-432-0001 (TTY: 711)**.

**Español (Spanish)** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-432-0001 (TTY: 711)**.

**繁體中文 (Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-866-432-0001 (TTY: 711)**。

**Tiếng Việt (Vietnamese)** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-866-432-0001 (TTY: 711)**.

**한국어 (Korean)** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-866-432-0001 (TTY: 711)**번으로 전화해 주십시오.

**Français (French)** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-866-432-0001 (ATS : 711)**.

**Tagalog (Tagalog – Filipino)** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-432-0001 (TTY: 711)**.

**Русский (Russian)** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны

бесплатные услуги перевода. Звоните **1-866-432-0001 (телетайп: 711)**.

**Deutsch (German) ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-866-432-0001 (TTY: 711)**.

**ગુજરાતી (Gujarati):** સુચના :જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે .ફોન કરો **1-866-432-0001 (TTY: 711)**.

**العربية (Arabic)**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-432-0001 (رقم هاتف الصم والبكم: 711)**.

**Português (Portuguese):** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-866-432-0001 (TTY: 711)**.

**日本語 (Japanese) 注意事項 :** 日本語を話される場合、無料の言語支援をご利用いただけます。**1-866-432-0001 (TTY: 711)** まで、お電話にてご連絡ください。

**Українська (Ukrainian):** УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-866-432-0001 (телетайп: 711)**.

**हिंदी (Hindi):** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-866-432-0001 (TTY: 711)** पर कॉल करें।

**ខ្មែរ (Cambodian):** ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ **1-866-432-0001 (TTY: 711)**។