**Appeal, Complaint or Grievance Form**

*If you have a complaint or appeal related to your Humana plan or any aspect of your care, we want to hear about it and see how we can help. You can use this form to tell us what happened and how you’re feeling. Please provide complete information, so we can get your issue to the associate who can help you best.*

*This form, along with any supporting documents (such as receipts, medical records, or a letter from your doctor) may be sent to us by mail or fax:*

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

**Fax Number:** 1-888-556-2128

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**1 Who is the member?**

<table>
<thead>
<tr>
<th>Member name (first and last)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Humana member ID number</td>
<td>Member birthdate (MM/DD/YY)</td>
</tr>
<tr>
<td>Person acting on member’s behalf (if someone other than the member)</td>
<td></td>
</tr>
<tr>
<td>Street address</td>
<td>City</td>
</tr>
<tr>
<td>State</td>
<td>Zip code</td>
</tr>
<tr>
<td></td>
<td>Phone number (with area code)</td>
</tr>
</tbody>
</table>

**2 What was the issue?**

*First, help us understand what this was about:*

- □ A medication
- □ A medical service (or medical equipment)
- □ An issue not related to a specific medical service or medication

*For a specific medical service or medication, please provide the details:*

<table>
<thead>
<tr>
<th>Service or medication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider (Physician, Facility, Prescriber)</td>
<td></td>
</tr>
<tr>
<td>Provider phone number (with area code)</td>
<td>Provider fax number</td>
</tr>
<tr>
<td>Have you already received the service or medication?</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

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What should we know about this issue? Please be as specific as possible about what happened and who was involved. Include any dates of service or contact with Humana employees, healthcare providers or pharmacies. If you run out of room, feel free to write on the back or add an extra page.

What additional information can you share? Please attach copies of any supporting information or documents that we should review, such as receipts for medications or services already paid for, medical records, or a letter from your provider.

What documents have you attached?:
- Receipt(s)
- Medical Bill(s)
- Medical Records
- Letter from your provider
- None
- Other ____________________________
Does your appeal need to be expedited? Expedited appeals are only appropriate for services that haven’t been rendered yet and if you and your provider believe that waiting for a standard decision could seriously harm your life, health or ability to regain maximum function. To process an expedited appeal, we’ll need your provider to share a statement indicating why your request should be expedited.

☐ Please check this box if you need an expedited decision within 72 hours, and you have a supporting statement from your provider.

Do you need to appoint a representative?

Skip this section if you are the member acting on behalf of yourself.

If you are not the member and aren’t sure if you’re authorized to work with Humana on the member’s behalf, please complete this section with the member. (Note: If you are a provider or legal representative, you will need to complete a separate Appointment of Representative Form that can be found at Humana.com.)

I, _____________________________, appoint _____________________________ to act on behalf of _____________________________ in connection with any claim for coverage or benefits identified in this case including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan only in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

I, _____________________________, hereby accept the above appointment.

| Member’s Medicare Number (beneficiary as party) or Beneficiary Identifier (MBI) |
|------------------------------|------------------|
| Representative name (first and last) | Relationship to member |
| Street address | City |
| State | Zip code |
| Phone number (with area code) |
Thanks for taking the time to inform us of this issue. We’ll be in touch with you if we have any questions, and we’ll get back to you as soon as we complete our investigation of the issue.

Humana is a Medicare Advantage HMO, PPO and PFFS organization and a stand-alone prescription drug plan with a Medicare contract. Enrollment in any Humana plan depends on contract renewal.
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 identity, or religion. 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 1-877-320-1235 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 the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).


Auxiliary aids and services, free of charge, are available to you.
1-877-320-1235 (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.

Language assistance services, free of charge, are available to you.
1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으러면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis ëd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d’aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

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

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi): بگیرید تماس فوق شماره با رایگان بصورت زیانی تسهیلات دریافت برات.

Diné Bizaad ĒNavajo: W0dah7 b44sh bee hani’7 bee wolta’7g77 bich’9’ h0d77lnih 47 bee t’11 jiik’eh saad bee 1k1’1n7da’1wo’d66 nik1’adoowo[.]

لغتنك للمساعدة مجانية خدمات على للحصول أعلاه المميز بالرقم الاتصال الرجاء

GCHJV5REN 1018