HUMANA®

P.O. Box 14546
Lexington, KY 40512-4546

GRIEVANCE/APPEAL REQUEST FORM

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

Member Name:	
Member ID #:	Date of Birth:
Authorized Representative*:	
Phone Number:	
Address:	

Service or Claim that was denied	
Provider Name	
Date of Service	

Please explain your grievance/appeal, or complaint and your expected resolution. (You may attach extra pages if you need more space.)

Member (or Representative) signature ____________________ Date ____________________

Relationship to Member (if Representative) ____________________

IMPORTANT: This form must be returned to the following address for prompt resolution of your request:

Humana Inc.
Grievance and Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

*You can get an *Appointment of Authorized Representative Form (AOR)* by using the link on our Website where you found this form. An AOR is not required for children under age 18 or for a handicapped dependent if the representative is a parent or legal guardian that is on the policy or is the appointed representative. If you are not on the policy or the appointed representative, we would need proof of legal guardianship or a signed AOR from the parent on the policy appointing you as the representative.

GF-6_GAR W