

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

1 Who is the member?

Member name (first and last)		
Humana member ID number		Member birthdate (MM/DD/YY)
Person acting on member's behalf (if someone other than the member)		
Street address		City
State	Zip code	Phone number (with area code)

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:

Service or medication	
Provider (Physician, Facility, Prescriber)	
Have you already received the medical service or medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Service date (MM/DD/YY)	Claim number (if you have one)

3 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
Name of Member Name of Representative

on behalf of _____ in connection with any claim for coverage or
Name of Member (or member's dependent)

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.
Name of Representative

Member's Medicare ID Number or HICN (on Member's Medicare card)		
Representative name (first and last)		Relationship to member
Street address		City
State	Zip code	Phone number (with area code)

4 Sign and Submit

Member Signature (or prescribing physician)

Date

Authorized Representative Signature (if you filled out section 3)

Date

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.

Discrimination is Against the Law

Humana Inc. and its subsidiaries (“Humana”) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235 or if you use a TTY, call 711.

If you believe that Humana has 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

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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Multi-Language Interpreter Services

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

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (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 (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 (TTY: 711).

한국어 (Korean): 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다. (TTY: 711)번으로 전화해 주십시오 .

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

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (телетайп: 711).

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (TTY: 711).

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

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (TTY: 711).

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

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (TTY: 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 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。(TTY: 711) まで、お電話にてご連絡ください。

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) تماس بگیرید.

Diné Bizaad (Navajo): Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq, kojí' hódíłnih (TTY: 711).