Humana®

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 number:	Date of birth:
Authorized Representative*	
Phone Number	
Address	

Service or Claim number
Provider name
Date of service:

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

* We must have an Appointment of Authorized Representative (AOR) form or other legal documentation when a request for a grievance and/or appeal is submitted by someone other than the member. If this form or other legal documentation is not on file, we are unable to continue your appeal or grievance.

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Member (or Representative) signature

Date

Relationship to member (if Representative)

Important: Return this form to the following address for resolution of your grievance or appeal:

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

Humana Integrated Care Program of Illinois

Call if you need us
If you have questions, you can call us at 1-800-764-7591 (TTY: 711). We're available Monday – Friday, from 8 a.m. – 8 p.m. Central time. However, please note that our automated phone system may answer your call after hours, during weekends, and holidays. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Visit Humana.com for 24 hour access to information like claims history, eligibility, and Humana's drug list. There you can also use the physician finder and get health news and information.

PS: This information is available for free in other languages and formats including oral interpretation. Please contact us at the number provided above.

PD: Esta información está disponible en otros idiomas y formatos sin costo alguno, incluso la interpretación oral. Contáctese con nosotros al número indicado arriba.