

**APPEAL REQUEST FORM**

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

|  |  |
| --- | --- |
| Member name: | <member name> |
| Member ID number: | <member ID number> | Date of birth: | <member date of birth> |
| Authorized Representative\*: |  |
| Phone Number: |  |
| Address: |  |
|  |  |
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|  |  |
| --- | --- |
| Service or Claim number: |  |
| Provider name: |  |
| Date of service: |  |

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| Please explain your appeal and your expected resolution. Attach extra pages if you need more space. |
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| Member (or Representative) signature |  | Date |
|  |  |  |
|  |  |  |
| Relationship to member (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: 1-800-949-2961