



INSTRUCTIONS FOR COMPLETING THE MEMBER REQUEST FOR AN APPEAL OR GRIEVANCE FORM

Purpose of the Form

This form is intended for member use to request an **appeal** of a decision by Community Family Care to provide a particular prescription(s).

This form can also be used by members to file a **grievance** regarding dissatisfaction with any aspect of the operations, activity, behavior of Community Family Care, or its providers.

PLEASE NOTE:

This form must be forwarded to Community Family Care. Please be sure that the authorization and consent sections are signed and dated prior to submitting the form.

Oral supporting statements can be made to Community Family Care by calling **715-838-2900 local and TTY or 1-800-842-1814**.

Upon completion, the form can be sent by **facsimile to 715-838-2910**. Or **mailed to:**

Community Family Care
Attn: Appeal and Grievance Coordinator
2240 EastRidge Center
Eau Claire, WI 54701