



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 Health Partnership 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 Health Partnership, or its providers.

PLEASE NOTE:

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

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain, or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins, and fluoride preparations).

Oral supporting statements can be made to Community Health Partnership 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 Health Partnership

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