



2240 EastRidge Center
 Eau Claire, WI 54701
 PH: (715) 838-2900 - OR - (800) 842-1814
 FX: (715) 838-2910
 WEB: www.communityhealthpartnership.com

Member Request for Appeal or Grievance

Member name _____ Contract number H5206
 Member date of birth _____ Daytime phone _____

Please summarize your complaint. (Give a brief description of the situation, your condition and medical treatment, if applicable. If you need more space for your summary, please attach an additional sheet to this form.)

Please fill out this table about the physicians seen for the condition above:

Physician(s) name and telephone number(s)	Date(s) of services	Type of service (surgery, ER visit, prescription drug, etc)	Billed amount (if any)

Authorization of a member representative (if applicable)
 I have completed the Appointment of Representative Form and I authorize _____ to represent me in this appeal/grievance and all related matters. **(Note: Please attach a signed Appointment of Representative Form.)**
 Signature of member: _____ Date: _____

Return to:
 Community Health Partnership
 Attention: Grievance and Appeals Coordinator
 2240 EastRidge Center
 Eau Claire, WI 54701
 Fax: (715) 838-2910