

**APPENDIX 1 – MEMBER REQUEST FOR APPEAL OR GRIEVANCE FORM**



A Program of Partnership Health Plan, Inc.

2240 EastRidge Center  
Eau Claire, WI 54701  
715/838-2900 • 800/842-1814  
Fax: 715/838-2910

**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 copy of the 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**  
**Telephone: 715-838-2900 or (800) 842-1814**  
**Fax: 715-838-2910**

If you have any questions or want an expedited appeal, please contact the Grievance and Appeals Coordinator at 715-838-2900. For Voice/TTY services, call toll free at 1-800-842-1814. The hours of the Customer Service Department are 8:00 AM – 4:30 PM, Monday through Friday.