

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.