



COMMUNITY HEALTH PARTNERSHIP
HMO SNP

A Program of Partnership Health Plan, Inc.

2240 EastRidge Center

Eau Claire, WI 54701

Voice/TTY: (715) 838-2900

TollFree: (800) 842-1814

Fax: (715) 838-2910

WEB: www.communityhealthpartnership.com

Member Request for Appeal or Grievance

This form is for your use in filing a formal complaint or appeal regarding any aspect of the care or service provided to you. If you have any questions or need help completing this form, please feel free to contact the Member Advocate or Grievance and Appeals Coordinator at (715) 838-2900, Voice/TTY or (800) 842-1814. **Please print or type the following information:**

Member name _____ Member ID# _____

Member date of birth _____ Daytime phone _____

Member Address: _____ City, State, Zip _____

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

Once you have completed this form, a Community Family Care staff member will contact you to discuss your concerns. In order to help resolve your appeal, Community Family Care staff may need to discuss your concerns with other individuals.

Authorization of 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.)**

Return to:

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

Signature of member: _____ Date: _____