WINDSOR MedicareExtra®

WINDSOR Rx®

MEMBER GRIEVANCE AND APPEAL FORM

TO: Windsor Health Plan, Inc.
Attention: Grievance & Appeals Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

FROM: Member's Name: _____ _____ _____
First M Last

Member Identification Number: _____

Telephone Number: __(_____)_____

Address: _____
Street Number and Name

_____ _____ _____
City State Zip Code

Description of the service/item/prescription in question (If applicable):

_____

Description of your grievance and/or appeal (Please use additional pages as needed):

_____

_____

_____

_____

_____

_____ _____
Signature of Member or Representative* **Date**

*If someone other than the member is requesting the grievance/appeal, please include an Appointment of Representative form or other legal papers supporting that person's status as the member's authorized representative.

Call: 1-800-316-2273 for assistance in completing this form or if you have any questions.
1-800-848-0298 TTY
7 days a week, 7:00 a.m. to 8:00 p.m. Central Time

H5698_H1850_S2505 HLTH042 0107
CMS Approval 0207