MEMBER GRIEVANCE AND APPEAL FORM

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

Fax: (615) 782-7971

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):

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

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____ __________________
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

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CMS Approval 02/2007