



MEMBER GRIEVANCE AND APPEAL FORM

TO: Windsor Rx
P.O. Box 22524
Salt Lake City, Utah 84112-2524
Fax: (877) 667-1895
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