

Humana Veterans  
Healthcare Services  
P.O. BOX 740013  
Louisville, KY 40201



## Application Request for Formal Grievance

Veteran Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_  
Veteran Address: \_\_\_\_\_  
Daytime Telephone Number: (\_\_\_\_) \_\_\_\_\_ Evening No.: (\_\_\_\_) \_\_\_\_\_

*If you are not the veteran or the legal guardian/representative of the veteran, please complete:*

Your Name: \_\_\_\_\_ Your Relationship to the Veteran: \_\_\_\_\_  
Your Current Address: \_\_\_\_\_  
Daytime Telephone Number: (\_\_\_\_) \_\_\_\_\_ Evening No.: (\_\_\_\_) \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- **Please Note: If you are not the veteran, then one (1) of these additional pieces of information will be required in order for HVHS to review your grievance.**
  - **Current Power of Attorney (POA)**
  - **Authorization of Representation Form (AOR)**
  - **Court order documentation, naming you as legal guardian/representative of the veteran**

*\*The AOR form may be requested from HVHS customer service by calling 1-866-458-6630.*

### **GRIEVANCE:**

*Please explain the grievance; provide as much information as possible. If your grievance is about a provider, please identify the provider and the date of service. Attach additional sheets if necessary.*

Provider's Name: \_\_\_\_\_  
Date(s) of Service: \_\_\_\_\_

### **Description of the Grievance:**

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How might HVHS most appropriately resolve your concern(s)?

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**INSTRUCTIONS:** Please complete this form (2 pages) and attach all supporting documentation. Please submit by mail to:

**Humana Veterans Healthcare Services,  
ATTN: Grievance Department  
P.O. BOX 740013  
Louisville, KY 40201**