



Appeal and Grievance Form

You may use this form or send us the details in writing (a letter) with your signature

Select (X) your complaint type below

A “Grievance” is the type of complaint you make if you have any problem **not** involving payment for care or services with WHP or one of our plan providers. Please refer to your EOC for additional information.

An “Appeal” is a type of complaint about services or payment disputes. Please refer to your EOC for additional information.

Mail to: Welborn Health Plans
Appeals & Grievance Department
101 S.E. Third St.
Evansville, IN 47708

Date: ____/____/____

Call: (812) 426-6600 or (800) 521-0265
TTY: (800) 743-3333

Your Name (please print): _____

Your Current Address: _____

City: _____ State: _____ Zip: _____ - _____

Your Phone Number: (____) _____ - _____ ID# _____

Details of your complaint (use additional sheets as needed): _____ This is page 1 of _____

Signed: _____

Be sure to sign your complaint on the last page or we will not be able to proceed . Thank you.

~OR~

Continued on next page

Spaces Below for Office Use Only

Date received by WHP



Appeal & Grievance Continuation Form

Page _____ of _____

Your Name (please print on each page): _____

Details of your complaint continued:

Signed: _____

Be sure to sign your complaint on the last page or we will not be able to proceed . Thank you.

~OR~

Continued on next page # _____

