

**TO:**

Windsor Medicare Extra  
Attention: Grievance & Appeals Department  
7100 Commerce Way, Suite 285  
Brentwood, TN 37027

Fax: 615-782-7828

**FROM:**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Member Identification Number: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

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 (TTY users, please call 711), 7 days a week, 8 a.m. to 8 p.m.**