coordinated care™
1145 Broadway, Suite 300
Tacoma, WA 98402

Appeal Request Form

If you wish to file an appeal* in writing, you may use this form. You can also write a letter that includes the information requested below, or you may file an appeal by phone, fax, or in person.

If you wish to file an appeal by phone, call us at 1-877-644-4613 or TDD/TTY 1-866-862-9380. To file appeal in writing, mail or fax the completed form or your letter to:

Coordinated Care of Washington, Inc.
Attn: Member Services Department
1145 Broadway, Suite 300
Tacoma, WA 98402
Fax: 1-866-270-4489

Member's Name: _____

Member's Medicaid #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Member Phone Number: _____

What are you appealing?

Tracking Number (if applicable, found in upper left hand corner of Denial letter): _____

Additional information to support the grievance, appeal, concern or recommendation (or attach):

Member or Representative Signature: _____

Daytime Phone #: _____ **Date:** _____

***You must file an appeal within sixty (60) calendar days of the date of the Denial Letter.**