coordinated care
1145 Broadway, Suite 700
Tacoma, WA 98402

Member Grievance Form

Coordinated Care of Washington, Inc. is committed to you. If you are dissatisfied with the quality of care that you have received, feel your doctor or a member of their staff were rude to you or you feel that your rights as a health plan member have been affected, you can file a grievance.

You may do this using one of these options:

1. You can fill out this form and mail or fax it to us **or**
2. You can mail or fax a letter that includes the information requested below **or**
3. You may call us at the number below and a Member Services Representative will assist you in submitting your grievance.

To contact Member Services:
Phone: 1-877-644-4613
TTY: 711

To fax a completed form or letter:
Fax: 1-877-212-6668

To send a completed form or letter:
Coordinated Care
Grievance Department
1145 Broadway, Suite 700
Tacoma, WA 98402

Please provide all of the following information:			
Member Name:			
Member Medicaid #:			
Member Street Address:			
City:		State:	
Zip Code:			
Member Phone Number: (please include area code)			
Please tell us about the grievance (when did it happen, who was involved and what happened). Please include any additional information that will be helpful in reviewing your concerns. (Use additional pages if needed).			
Who is submitting this form?			
Daytime Phone Number: (please include area code)		Date:	