coordinated care
1145 Broadway, Suite 700
Tacoma, WA 98402

Appeal Request Form

Coordinated Care of Washington, Inc. is committed to you. If you do not agree with a decision we made about care you or your provider think you need, you can file an appeal.

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. You may file an appeal by mail, phone, fax, email or in person. You must file your appeal within 60 days of the date on the denial letter.

If you wish to file an appeal by phone, call us at 1-877-644-4613 or TTY 711.

To file appeal in writing, send the completed form or your letter to:

Coordinated Care of Washington, Inc.
Attn: Pharmacy Appeal Department
PO Box 31398
Tampa, FL 33631-3398
Fax: <<1-888-865-6531/1-844-235-5091>>

If you want another person to help you with this appeal, you must fill out the Authorized Representative form on our Website at: **Filing an Appeal | Medicaid Resources | Coordinated Care**

Member's Name: _____

Member's Medicaid #: _____

Street Address: _____

City, State, Zip: _____

Member Phone Number: _____

What are you appealing? _____

Tracking Number (if available, found in upper left-hand corner of denial letter): _____

Additional information to support the appeal (or attach): _____

_____

_____

Member Signature: _____

Date: _____