coordinated care
1145 Broadway, Suite 700
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 TTY 711. To file appeal in writing, mail or fax the completed form or your letter to:

Coordinated Care of Washington, Inc.
Attn: Appeal Department
1145 Broadway, Suite 700
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 available, found in upper left-hand corner of denial letter): _____

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

_____

_____

_____

**Member or Representative Signature:** _____

**Daytime Phone Number:** _____ **Date:** _____

***You must file an appeal within six (60) calendar days of the date of the denial letter.**