coordinated care
1145 Broadway, Suite 700
Tacoma, WA 98402

Member Authorized Representative Form

You may have someone represent you in an appeal. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form. If you need our assistance, please call us at 1-877-644-4613 (TTY: 711). Complete all sections on this form (if all areas are not completed the form cannot be accepted) and mail, fax, or email to:

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

Member Name: _____

Member ID Number: _____

Member Street Address: _____

Member City, State, Zip: _____

Member Phone Number: _____

I want the following person to represent me in my Appeal. I understand that personal medical information related to my appeal may be disclosed to my representative.

1. Representative Name, Address, Phone (Please Print):

2. Brief description of the appeal for which the Representative will be acting on my behalf, or Tracking # (Authorization #):

Member Signature: _____ Date:_____