Dear _____,
(Member Name)

_____ has filed an appeal on your behalf.
(Provider Name)

The appeal is for _____
_____

Your signature is needed before we can move forward with the appeal. Please sign this form to give us permission to work with your provider for this appeal. We cannot speak with anyone on your behalf until we receive this form. Please call us if you have questions. We can be reached by phone at: 1-877-644-4613 or TDD/TTY 1-866-862-9380.

Return this form by mail to:

Coordinated Care
Appeal Department
1145 Broadway, Suite 300
Tacoma, WA 98402

By fax to:

1-866-270-4489

I, _____ want _____
(Member Name) (Provider Name)
to act for me in my Appeal with Coordinated Care.

Member Signature:

_____ / _____
Signature of Member (or parent/guardian) Relationship to Member

Date: _____