ambetter. FROM coordinated care.
1145 Broadway, Suite 700
Tacoma, WA 98402

Authorized Representative Designation
Coordinated Care Corporation

We want you to know that you may have someone act on your behalf in an appeal. The person you list below will be designated as your representative for the appeal. We will not be able to provide information to or accept information from another individual besides your doctor until we receive this authorization.

I,_____, want the following person to act for me in my appeal. I understand that personal medical information related to my appeal may be disclosed to my representative.

Name and Address of Representative (please print):

_____
Name

_____
Street Address, including Apartment Number or Post Office Box

_____ _____ _____
City State Zip Code

Phone Numbers of Representative:

(_____)_____ (____)_____
Daytime Phone Number Evening Phone Number

Brief description of the appeal for which the representative will be acting on my behalf:

_____

Member Signature: _____

Date of Signature: _____
If not member, relationship to member: ☐ Parent ☐ Guardian

Member's Date of Birth:_____ Member's ID Number: _____

Please return this completed form to:

Ambetter from Coordinated Care
Appeals Department
1145 Broadway, Suite 700
Tacoma, WA 98402

Phone: 877-687-1197
TTY: 711
Fax: 855-218-0589