Member Grievance Form

Ambetter from Coordinated Care Corporation is committed to you. If you are dissatisfied with the quality of care that you have received, feel your doctor or a member of their staff were rude to you or you feel that your rights as a health plan member have been affected, you can file a grievance.

You may do this using one of these options:

1. You can fill out this form and mail or fax it to us **or**
2. You can mail or fax a letter that includes the information requested below **or**
3. You may call us at the number below and a Member Services Representative will assist you in submitting your grievance.

To contact Member Services:

Phone: 1-877-687-1197
TTY 1-877-941-9238

To fax a completed form or letter:

Fax: 1-855-218-0588

To send a completed form or letter:

Ambetter from Coordinated Care
Grievance Department
1145 Broadway, Suite 300
Tacoma, WA 98402

Please provide all of the following information:		
Member Name:		
Member Number:		
Member Street Address:		
City:		State**:**
Zip Code:		
Member Phone Number: (Include area code)		
Please tell us about the grievance (when did it happen, who was involved and what happened). Please include any additional information that will be helpful in reviewing your concerns. (Use additional pages if needed).		
Who is submitting this form?		
Daytime Phone Number: (please include area code)		Date: