ambetter. FROM coordinated care.
1145 Broadway, Suite 300
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, email or in person.

If you wish to file an appeal by phone, call us at 1-877-687-1197 or TTY 1-877-941-9238.

To file a written appeal, mail, email or fax the completed form or your letter to:

Coordinated Care Corporation
Appeals Department
1145 Broadway, Suite 300
Tacoma, WA 98402

Fax: 1-855-218-0589 E-Mail: Tac_WAAppealDept@Centene.com

Member's Name: _____

Member's Ambetter ID: _____

Street Address: _____

City, State, Zip:

Member Phone Number:_____

What are you appealing? _____

_____

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

_____

_____

Member or Representative Signature: _____

Relationship if not Member:

Daytime Phone #:_____Date: _____

***You must file an appeal within one hundred and eighty (180) calendar days of the date of the denial.**