Ambetter from Coordinated Care Appeal Form

An appeal is a request to review a denied service or referral. You can appeal our decision if a service was denied, reduced, or ended early. If you wish to file an appeal in writing, you may use this form or you can write a letter that includes the information requested below. You may file an appeal by phone, fax, or in person. **You must file an appeal within 180 days of the date on the denial letter.**

The completed form can be returned by mail or fax.

Mail:
Coordinated Care, Attn: Ambetter Member Appeals
1145 Broadway, Suite 300, Tacoma, WA 98402

Fax: 1-855-218-0589

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

Requested Information:

Member Name:_____

Member ID#:_____

Street Address: _____

_____

City State Zip

Member Phone Number:_____

Tracking Number (if applicable, found in upper left hand corner of denial letter):

_____

Additional information to support the grievance, appeal, concern or recommendation (or attach):

_____

_____

_____

_____

_____

Member or Representative Signature*: _____

* Representative, please describe relationship:_____

Daytime Phone #:_____Date:_____