



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

**APPEAL REQUEST FORM**  
**Coordinated Care Corporation**

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 711.

To file appeal in writing, mail, email or fax the completed form or your letter to:

Ambetter from Coordinated Care  
 Appeals Department  
 1145 Broadway, Suite 700  
 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: \_\_\_\_\_

Daytime Phone #: \_\_\_\_\_ Date: \_\_\_\_\_

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