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

Washington State Appeal Request Form
Coordinated Care Corporation

If you are a Washington state member of Ambetter from Coordinated Care and wish to file an appeal in writing, you may use this form. You can also write a letter that includes the information requested below. You may file an appeal by mail, phone, fax, email or in person. You must file your appeal within 180 days of the date on the denial letter.

If you wish to file an appeal by phone, call us at 1-877-687-1197 or TTY: 711.

To file an appeal in writing, send the completed form or your letter to:

Ambetter from Coordinated Care
Pharmacy Appeal Department
PO Box 31398
Tampa, FL 33631-3398
Retail Pharmacy Appeal Fax: 1-888-865-6531
Medpharm Appeal Fax: 1-844-235-5091

Member's Name: _____

Member's Ambetter ID: _____

Street Address: _____

City, State, Zip: _____

Member Phone Number: _____

What are you appealing? _____

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

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

_____

Member Signature: _____

Date: _____

This form is specifically for Ambetter from Coordinated Care members in Washington state. If you're from another state, please visit your local Ambetter website to find the right form for you.