1145 Broadway, Suite 300
Tacoma, WA 98402

Date:

You may have someone represent you in an appeal. The person you list below will be accepted as your representative. We cannot speak with anyone on your behalf until we receive this form. If you need our assistance, please call us at: Phone 1-877-644-4613; TDD/TTY 1-866-862-9380. Complete and mail or fax to:

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

Fax 1-866-270-4489

Member Name:_____ Date:_____

Member Medicaid Number:_____

I want the following person to represent me in my Appeal. I understand that personal medical information related to my appeal may be disclosed to my representative.

1. Representative Name, Address, Phone (Please Print):

2. Brief description of the appeal for which the Representative will be acting on my behalf:

Member Signature: _____ Date:_____