

Member Appeal Request

To **appeal a pre-service coverage decision** with Community Health Plan of Washington (CHPW) **Apple Health (Medicaid) members** can complete and send this form to start the process. This form is not required. You can also call **1-800-440-1561** (TTY: 711) 8 a.m. to 5 p.m. Monday through Friday.

Fast (expedited) appeal request: If your doctor feels that waiting more than 72 hours (3 days) for a decision could put your physical or mental health at serious risk, or if it involves a mental health or substance use disorder drug authorization, call us right away and send us any documents to support your request as soon as possible.

Appeal requests must be received by CHPW within 60 days of the date on your denial letter.

Email: AppealsGrievances@chpw.org (*preferred*)

Fax: 206-613-8984

Mail: Community Health Plan of Washington,
Attn: Appeals and Grievances,
1111 3rd Ave, Suite 400 Seattle,
Washington 98101-3207

Member Information	
Member First and Last Name	Date of Birth
CHPW Member ID Number	Parent, Legal Guardian, or Representative Name
Phone	Email
What are you appealing? (<i>Check what was denied</i>)	
<input type="checkbox"/> Prior Authorization <input type="checkbox"/> Medication <input type="checkbox"/> Referral	Name of Service, Medication, or Referral
Date on Denial Letter	Reference or Certification Number in Letter (<i>If available</i>)
<p>Appeal Summary Please share the reason for your appeal, and any important details we should consider during our review.</p>	

Provider Information

Provider First and Last Name

Clinic/Office Name

Phone

Please do not use this form if someone else will be representing you, including your doctor, or if you are filling out this form for a member and are not their parent/guardian. **Instead use Member Consent: Authorize a Representative.**

Signature

Date

Completed by: Self (Member) Parent or Legal Guardian Power of Attorney