Molina Healthcare of Washington
Appeal Request Form

If you want to appeal the decision we have made, please fill out this form and send it to us within 180 days of the date of the adverse benefit determination. If your healthcare provider thinks your life or health is in immediate danger because of the decision in the adverse benefit determination, he/she can ask for an expedited appeal by either calling Molina Healthcare of Washington or completing this form.

If you have questions or need help completing this form, please call 1 (888) 858-3492.

Please Print

Date: _____

Member's ID #: _____

Member's LAST name: _____

Member's FIRST name: _____ MI: _____

Current Address: _____ _____

City: _____ State: _____ Zip: _____

Phone number: _____

Doctor's Name: _____

Specific Issues: _____

_____

Please mail all supporting documentation regarding your appeal to:

Molina Healthcare of Washington
Attn: Grievance & Appeals
P. O. Box 4004
Bothell, WA 98041

Authorized Representative Permission Statement

If your healthcare provider or another individual is filing the Appeal for you, you must give your written permission.

I, _____ (your name), give my permission for

_____ (designee) to file this appeal form.

_____ _____
Client's Signature Date