Molina Healthcare of Washington

Apple Health Member Appeal Form

You may request an appeal within 60 calendar days of the date on the letter notifying you of the denial of services. If you need assistance in completing this form, please contact your managed care plan.

Member Name: ______________________________

Parent/Legal Guardian: ______________________________

ProviderOne ID: ______________________________

Service or Treatment you are appealing: ______________________________

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Tell us why you think our decision was wrong: ______________________________

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Member or Authorized Representative Signature:______________________________

Printed Name:______________________________

Authorized Representative Relationship to Member: ______________________ Date: __________

If you need your appeal reviewed urgently, please call us at (800) 869-7165 or TTD/TTY: 711.

Molina Healthcare
Attention: Member Appeals
PO Box 4004
Bothell, WA 98041-4004

Web: MolinaHealthcare.com
Fax: (877) 814-0342
Email: wamemberservices@MolinaHealthcare.com

Keep a copy of the fax confirmation for your records.

*By initialing,__________, I want my doctor or the person listed below to act on my behalf for this appeal.

Name: ______________________________

*An authorized representative must be chosen by the member, parent or legal guardian. A doctor may represent the member with the member's/responsible party's written consent. An authorized representative cannot make health care decisions about the financial responsibility of the member, parent or legal guardian unless it's put in writing.

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