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: _____

_____

_____

Tell us why you think our decision was wrong: _____

_____

_____

_____

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.

MHW PART #1373-2504, MHW-04/01/2025, HCA-10/6/2021 (2019-428)