Waiver of Liability Statement

my Advocate
MEDICARE ADVANTAGE

Enrollee's Name: _____

Enrollee ID Number: _____

Provider: _____

Date of Service: _____

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Provider Signature: _____ Date: _____

You may use the address below to return the form OR fax to 715-221-6616

MyAdvocate Medicare Advantage
PO Box 8000
Marshfield, WI 5449-8000