Waiver of liability statement

Medicare/health information claim number: _____

Enrollee's name: _____

Provider name: _____ Date of service: __ / __ / ____

Health plan: _____

Services:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 the code of federal regulations: 42 CFR 422.600.

Signature: _____ Date: ___ / ___ / ___

Send the completed form to

Fax to: 616.975.8827

Mail to: Priority Health Appeals Analyst
1231 E. Beltline Ave NE
MS 1150
Grand Rapids, MI 49525

Priority Health has HMO-POS and PPO plans with a Medicare contract. Enrollment in Priority Health Medicare depends on contract renewal.