Western Health Advantage Mail Service
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Western Health Advantage

Waiver of Liability Statement

Enrollee's Name ______________________________

Enrollee ID Number ______________________________

Provider ______________________________

Dates of Service ______________________________

Health Plan ______________________________

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.

Signature ______________________________

Date ______________________________