**WAIVER OF LIABILITY STATEMENT**

Enrollee’s Name Medicare/HIC 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

\*Please mail request for reconsideration to:

Alliance CompleteCare

Attn: Care Advisor Unit

1240 South Loop Rd.

Alameda, CA 94502