ALTERWOOD ADVANTAGE
Quality Care. Better Health.

Waiver of Liability Statement

Patient/Enrollee's Name: _____

Enrollee ID Number: _____

Health Plan: _____

Provider Name: _____

Date(s) 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