ALTERWOOD ADVANTAGE
Quality Care. Better Health.

WAIVER OF LIABILITY STATEMENT

Patient/Beneficiary Name	
Member ID	
Health Plan	**Alterwood Advantage**
Date of Service	
Provider/Group Name	

I hereby waive any right to collect payment from the above-mentioned enrollee for the services for which payment has been denied and/or reduced 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.

I certify that I am an authorized representative of the above Organization and have the legal authority to sign this Medicare Waiver of Liability form on its behalf. Third party billing companies cannot sign this form. If this form is not signed by an authorized representative, the appeal will be dismissed.

Provider Signature _____ Date _____

Print Name _____

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