El Paso Health+
Advantage Dual SNP

WAIVER OF LIABILITY STATEMENT

Member's Name _____ Medicare/HIC Number _____

Provider _____ Dates of Service _____

El Paso Health Advantage Dual SNP
Name of 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 _____