



WAIVER OF LIABILITY STATEMENT

Enrollee ID Number _____

Enrollee's Name _____

Provider _____

Date(s) 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 return completed form to:

SummaCare
Attn: Appeals
PO Box 1107
Akron, OH 44309-1107

SummaCare is an HMO and HMO-POS health plan with a Medicare contract.
Enrollment in SummaCare Medicare Advantage plans depends on contract renewal.

<SC MDCR 14_12_17 12122013>