# Waiver of Liability Statement

**Member ID Number** ______________________________

**Member Name** ______________________________

**Health Plan** ______________________________

**Provider** ______________________________

**Dates of Service** ______________________________

I hereby waive any right to collect payment from the above-mentioned member 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**

Return completed form by mail or fax to:

Highmark Health Options Duals
Attn: Appeals & Grievances
P.O. Box 890416
Camp Hill, PA 17089-0416
Fax: 1-833-560-1828

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