Waiver of Liability Statement

Enrollee's Name _____ Enrollee ID Number _____

Provider _____ Dates of Service _____

Great Plains Medicare Advantage
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 _____

You may use the address below to return the form OR FAX to (605) 312-8217

Great Plains Medicare Advantage/Sanford Health Plan
Attn: Appeals and Grievances Department
P.O. Box 91110
Sioux Falls, SD 57109