

## Waiver of Liability Statement

Enrollee's Name \_\_\_\_\_

Enrollee ID Number \_\_\_\_\_

Provider \_\_\_\_\_

Dates of Service \_\_\_\_\_

Great Plains Medicare Advantage

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.

Provider 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

PO Box 91110

Sioux Falls, SD 57109-1110