PREFERRED CARE NETWORK
A UnitedHealthcare Company

WAIVER OF LIABILITY STATEMENT

Member Name: _____ Medicare Number: _____

Plan Name: _____ Plan Identification Number: _____

Provider Name: _____ Exact Date of Service _____

Case Reference: _____

I hereby waive any right to collect payment from the above-mentioned member for the aforementioned services for which payment has been denied. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Please send this completed form (and other appropriate documentation, if applicable) to:

Medical Care - Part C

- MedicareMax (HMO)
- MedicareMax Chronic (HMO - CSNP)

Preferred Care Network Appeals & Grievance Department P.O Box 6106, MS CA124-0157 Cypress, CA 90630-0016

Medical Care - Part C

- MedicareMax Plus (HMO D-SNP)

Preferred Care Network Appeals & Grievance Department P.O Box 6106, MS CA124-0187 Cypress, CA 90630-0016

Prescription Drugs - Part D

- All plans

Preferred Care Network Appeals & Grievance Department P.O Box 6106, MS CA124-0197 Cypress, CA 90630-0016