WAIVER OF LIABILITY STATEMENT

Member Name: _____ Medicare #: _____

Plan Name: _____ Plan I.D. #: _____

Provider: _____ Date 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. 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:

UnitedHealthcare Dual Complete (HMO SNP)
Attention: Appeals Department
PO Box 30991
Salt Lake City UT 84130-0991

(or fax to: 1-248-559-5552)