Waiver Of Liability Form

Member Name: _____ Member ID #: _____

Provider Name: _____ Provider NPI #: _____

Date(s) of Service: _____

Service/Item Description: _____

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 Generations Advantage 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: _____

Please return completed forms via fax or mail.

Fax:

207-828-7874

Mail:

Martin's Point Health Care
Attn: Appeals Specialist
PO Box 8832
Portland, Maine 04104