



FROM |  coordinated care.

P.O. Box 3060
Farmington, MO 63640

WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee's Name

Provider

Dates of Service

Allwell from Coordinated Care of
Washington
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