PREMERA BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Waiver of Liability Statement

By completing and signing this form, you waive your right to collect payment from the following Premera Blue Cross Medicare Advantage member. Premera Blue Cross will not process your appeal request unless you include this form.

______________________	______________________
Enrollee Name	Medicare/HIC number

______________________	______________________
Provider Name	Dates of service

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 § C.F.R. 422.600.

______________________	______________________
Provider signature	Date

Send to:

Premera Blue Cross Medicare Advantage
Appeals and Grievances Department
P.O. Box 21481
Eagan, MN 55121