Waiver of Liability Statement

______________________________ _____________________
Enrollee's Name Enrollee ID Number

______________________________ _____________________
Provider Dates of Service

KeyCare Advantage
____
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

You may use the address below to return the form OR fax to 1-833-610-2380.

KeyCare Advantage
Attn: Appeals and Grievances Department
PO Box 607
Glen Burnie, MD 21060-0607