AlohaCare
For a healthy Hawaii.

Appendix 7 - Waiver of Liability Statement
(Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

WAIVER OF LIABILITY STATEMENT
FOR MEDICARE NON-PAR PROVIDERS ONLY

_____
Medicare/HIC Number

_____
Enrollee's Name

_____ _____
Provider Dates of Service

_____
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

Please mail this form, along with your request for an appeal (in writing) and all related documents to:

AlohaCare
Attn: Grievance & Appeals Division
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814