Waiver of liability statement

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

Enrollee name	**Member ID Number**
Provider name	**Dates of service** (mm/dd/yy)

Arkansas Blue Medicare

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 signed** (mm/dd/yy)

Return signed form by mail:
Arkansas Blue Medicare Appeals Department
PO Box 2181
Little Rock, AR 72203
or
Fax: 501-378-3366
Email: appealscoordinator@arkbluecross.com