



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association



Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

WAIVER OF LIABILITY STATEMENT

By completing and signing this form, you waive your right to collect payment from the Medi-Pak Advantage® member. Medi-Pak Advantage will not process your appeal request unless you include this form.

Medicare/HIC Number

Enrollee Name

Provider Name

Dates of Service

Medi-Pak 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.

Provider Signature

Date

Send to: Medi-Pak Advantage
Appeals and Grievance Unit
PO Box 441335
Detroit, MI 48244-1335