VILLAGECAREMAX

SEE WHAT'S POSSIBLE WHEN HEALTH CARE GETS PERSONAL.

P.O. Box 3025
Scranton, PA 18505
Phone: 1-855-769-2500
Fax: 1-833-203-5274
www.villagecaremax.org

WAIVER OF LIABILITY STATEMENT

Member ID/ Medicare Number: _____
Enrollee's Name: _____
Provider Name: _____
Dates of Service: _____
Health Plan: VillageCareMAX

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: _____

ONLY THE SERVICING PROVIDER CAN SIGN THIS FORM