P.O. Box 1489, Orange, CA 92856 | www.elitehealthplan.com

# Waiver of Liability Statement

Enrollee Name _____ Enrollee ID Number _____

Provider _____ Dates of Service _____

***Elite Health Plan (H6368)***

Health Plan _____

By signing below, I give up ("waive") any right to collect payment from the enrollee (above) for the item, service or Part B drug furnished to the enrollee that the enrollee's health plan has denied. I understand that signing this waiver doesn't negate my right to appeal under 42 CFR §422.600.

Signature _____ Date **____/_____/20_____**