1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000
1-888-298-4650

Waiver of Liability Statement

Enrollee Name

Enrollee ID Number

Provider

Dates of Service

MyAdvocate Medicare Advantage
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

Please return this form in the enclosed envelope to:

MyAdvocate MA
PO Box 8000
Marshfield, WI 54449-8000

Or fax to: 715-221-9424

Or email to: ProviderAppeals@MyAdvocateMA.com