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## Waiver of Liability Statement

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Enrollee's Name

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Enrollee ID Number

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Provider

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Dates of Service

Align Senior Care

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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.

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Signature

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Date

You may use the address below to return the form OR fax to 1-833-610-2380.

Align Senior Care  
Attn: Appeals and Grievances Department  
PO BOX 4440  
Glen Allen, VA 23058-4440