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## Waiver of Liability Statement

\_\_\_\_\_  
Enrollee's Name

\_\_\_\_\_  
Enrollee ID Number

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Dates of Service

Align Senior Care  
\_\_\_\_\_

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
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 40  
Glen Burnie, MD 21060-040