

**WAIVER OF LIABILITY STATEMENT**

\_\_\_\_\_  
Medicare/HIC Number

\_\_\_\_\_  
Member's Name

\_\_\_\_\_  
Provider

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

HPSM CareAdvantage Cal MediConnect Plan (Medicare-Medicaid Plan)  
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.

HPSM CareAdvantage Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date