1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000
1-877-509-4979

Waiver of Liability Statement

Enrollee Name

Enrollee ID Number

Provider

Dates of Service

Align powered by Sanford Health Plan
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 the appropriate department below:

Provider Post Service Claim Appeals:
Sanford Health Plan
Attn: Provider Appeals
PO BOX 8000
Marshfield, WI 54449-8000
Fax: 715-221-9650
Email: SHP-MA-ProviderAppeals@sanfordhealth.org

Member Appeals or Providers Appealing Pre-Service Denials:
Sanford Health Plan
Attn: Appeals & Grievances
PO BOX 8000
Marshfield, WI 54449-8000
Fax: 715-221-9424
Email: SHP-MA-MemberAppeals@sanfordhealth.org