# Waiver of Liability Statement

Enrollee's Name _____

Enrollee ID Number _____

Provider _____

Dates of Service _____

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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.

Provider Signature_____ Date _____

You may use the address below to return the form OR fax to (605) 312-8217

**Align powered by Sanford Health Plan**
Attn: Appeals and Grievances Department
PO Box 91110
Sioux Falls, SD 57109-1110