LONGEVITY
HEALTH PLAN

Waiver of Liability Statement

Enrollee's Name _____ Enrollee ID Number _____

Provider _____ Dates of Service _____

Longevity Health 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.

Signature _____ Date _____

You may use the address below to return the form OR fax to 1-855-969-5853.

Longevity Health Plan
Attn: Appeals and Grievances Department
P.O. Box 21063
Eagan, MN 55121