

## Waiver of Liability Statement

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

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

\_\_\_\_\_  
Provider

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

\_\_\_\_\_  
Simpra Advantage  
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 completed form.

Simpra Advantage  
Attn: Appeals and Grievances Department  
PO Box 981842  
El Paso, TX 79998-1842