Waiver of Liability Statement

Enrollee's Name

Enrollee's 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 20648
Tampa, FL 33622-0648