Waiver of Liability Form

Aetna® Medicare HIDE (HMO D-SNP)

Mail:
Aetna Medicare HIDE (HMO D-SNP)
PO Box 14727
Lexington, KY 40512-4727

Phone: 1-855-676-5772 (TTY: 711)
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WAIVER OF LIABILITY STATEMENT

_____ _____

Enrollee Name | Enrollee ID

_____ _____

Provider | Dates of Service

Aetna Medicare HIDE (HMO D-SNP)

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**