



## AETNA BETTER HEALTH®

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### WAIVER OF LIABILITY STATEMENT

\_\_\_\_\_  
Medicare/HIC Number

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

\_\_\_\_\_  
Provider

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

\_\_\_\_\_  
Aetna Better Health of IL  
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