



Waiver of Liability Form

AETNA BETTER HEALTH® OF MICHIGAN

Mail and/ or fax dispute to:

Mail:

Aetna Better Health® of Michigan

Attention: Provider Relations Department

1333 Gratiot Ave

Detroit, MI 48207

Fax:

1-860-975-3615

WAIVER OF LIABILITY STATEMENT

Enrollee Name

Medicare/HIC Number

Provider

Dates of Service

Aetna Better Health® of Michigan
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.



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Signature

Date