Aetna Better Health of Ohio Dual Preferred (HMO SNP)
7400 West Campus Rd.
New Albany, OH 43054

WAIVER OF LIABILITY STATEMENT

Enrollee Name

_____

Provider Name

_____

Health Plan

Aetna Better Health of Ohio
Dual Preferred (HMO SNP)

Enrollee ID

_____

Dates of Service

_____

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**