<Date>

<Provider Full Name>
<Address 1>
<City, State Zip>

Dear <Provider Name>,

In order for Rocky Mountain Health Plans (RMHP) to process your appeal of this Member's claim, Medicare requires that you sign and return this form. Your appeal cannot be processed until the completed form is received. We must receive the signed Waiver of Liability by <date> or the appeal will be dismissed.

WAIVER OF LIABILITY STATEMENT

____________________________ ____________________________
Enrollee's Name Enrollee ID Number

____________________________ __________________
Provider Dates of Service

Rocky Mountain Health Plans
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.

____________________________ ____________________________
Provider's Signature Date

Sincerely,

Member Appeals & Grievances Department
Rocky Mountain Health Plans