PrimeWest HEALTH
A greater Minnesota health plan™

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WAIVER OF LIABILITY STATEMENT

_____
PrimeWest Health Member ID

_____
Member's Name

_____
Provider/Facility

Tax ID _____ NPI _____

_____
Date(s) of Service

By signing this form, I hereby waive any right to collect payment from the abovementioned member for the aforementioned services for which payment has been denied by PrimeWest Health. I understand that the signing of this waiver does not negate my right to request further Appeal under Title 42 Code of Federal Regulations (CFR) Part 422.600.

_____ _____
Signature Date

_____
Name

_____
Title