



Waiver of Liability
Statement

Gateway Health Plan® ID

Member's Name

Provider Name

Dates of Service

I 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

Printed Name

Gateway Health Plan *Medicare Assured*® is a Medicare approved Special Needs Plan for individuals who have both Medicare and Medical Assistance