Clear Spring Health

Waiver of Liability Statement

Enrollee's Name:
Medicare Number/Enrollee ID Number:
Provider Name:
Health Plan Name/Medicare Contract Number:
Date 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

_____ _____

Print Name Title

Please submit this form to:
Clear Spring Health

Attn: Appeals and Grievances Department

3601 SW 160th Avenue
Suite 450
Miramar, FL 33027

Fax: 1-866-235-5181

If you have any questions, please call Clear Spring Health at 1-877-364-4566. TTY users should call 711. We are open from October 1–March 31, seven days a week, 8:00 am – 8:00 pm and from April 1 – September 30, Monday through Friday, 8:00 am – 8:00 pm (you may leave a voicemail Saturday, Sunday, and Federal Holidays).

Thank you,

Clear Spring Health

Appeals and Grievances Department