Preferred Care Partners Waiver of Liability Statement

Member Name: ______________________ Medicare Number: ______________________

Plan Name: ______________________ Plan Identification Number: ______________________

Provider Name: ______________________ Exact Date of Service: ______________________

Case Reference: ______________________

I hereby waive any right to collect payment from the above-mentioned member for the aforementioned services for which payment has been denied. 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 send this completed form (and other appropriate documentation, if applicable) to:

Medical Care - Part C&B

- UHC Preferred Medicare Advantage FL-0001 (HMO)
- UHC Preferred Medicare Advantage FL-0002 (HMO)
- UHC Preferred Medicare Advantage FL-002P (HMO)
- UHC Preferred Complete Care FL-0003 (HMO C-SNP)

Preferred Care Partners
Appeals & Grievance Department
P.O Box 6106, MS CA 120-0360
Cypress, CA 90630-0016

Medical Care - Part C&B

- UHC Preferred Dual Complete FL-D001 (HMO D-SNP)
- UHC Preferred Dual Complete FL-D01P (HMO D-SNP)
- UHC Preferred Dual Complete FL-V1 (HMO D-SNP)
- UHC Preferred Dual Complete FL-Y2 (HMO-POS D-SNP)
- UHC Preferred Dual Complete FL-V2 (HMO D-SNP)
- UHC Preferred Dual Complete FL-Y3 (HMO-POS D-SNP)

Preferred Care Partners
Appeals & Grievance Department
P.O Box 6106, MS CA 120-0360
Cypress, CA 90630-0016

Prescription Drugs - Part D

- All plans

Preferred Care Partners
Appeals & Grievance Department
P.O Box 6106, MS CA120-0368
Cypress, CA 90630-0016

Not for distribution to retirees or beneficiaries