Waiver of Liability
Non-participating Provider

Medicare Number:	
Member Name:	
Provider Name:	Date of Service:
Health Plan: **Group Health Cooperative of Eau Claire**	
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:

Please complete and submit with your Provider Appeal Form to:

Group Health Cooperative of Eau Claire
ATTENTION: PROVIDER APPEALS
P.O. Box 3217
Eau Claire, WI 54702-3217