Waiver of Liability Statement

_____
Medicare/HIC Number

_____
Enrollee's Name

_____ _____
Provider Dates of Service

_____
Health Plan

In order to comply with CMS, Center of Medicare and Medicaid Services, we appreciate if you read, sign and send this letter within 30 calendar days to the Appeals and Grievances Department. We will evaluate your case within the next 60 calendar days once this letter is received. Please read carefully the following paragraph.

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by MMM Healthcare, LLC. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

_____ _____
Signature *Date*

Source: CMS Medicare Managed Care Manual Chapter 13 Appendix 7- Waiver of Liability Statement (Rev.105, Issued: 04-20-2012, Effective Date: 04-20-1; Implementation Date: 04-20-2012)

Exención de Responsabilidad

_____
Número Medicare/HIC

_____
Nombre del Afiliado (a)

_____ _____
Proveedor Fecha de Servicio

_____
Plan de Salud

Con el fin de cumplir con CMS, Centro de Servicios de Medicare y Medicaid, apreciamos si usted lee, firma y envía esta carta dentro de los 30 días calendario al Departamento de Apelaciones y Querellas. Evaluaremos su caso dentro de los siguientes 60 días calendario una vez que esta carta sea recibida. Lea detenidamente el siguiente párrafo.

Por la presente, renuncio a cualquier derecho a cobrar el pago a la persona inscrita arriba mencionado y por los servicios antes indicado, para los que el pago ha sido denegado por MMM Healthcare,LLC. Yo entiendo que la firma de esta renuncia, no niega mi derecho a solicitar una apelación bajo 42 CFR §422.600.

_____ _____
Firma *Fecha*

Referencia: CMS Medicare Managed Care Manual Capítulo 13 Apéndice 7- Renuncia a la Declaración de responsabilidad (Rev. 105, Publicado: 04-20-2012, fecha de vigencia: 04-20-1; Implementación Fecha: 04-20-2012)

Non Contracted Provider Payment Dispute Form

(APPLIES ONLY FOR DISPUTES TO UNDER MEDICARE FEE PAYMENT OR DOWNCODE)

(Please read instructions below)

PROVIDER INFORMATION

☐ Physician ☐ Facility Medicare ID: ☐☐☐☐☐☐☐☐☐☐☐

Provider Name _____ Contact _____

Rendering Provider NPI _____ Telephone _____

Billing Provider NPI _____ Fax Number _____

Member Name	Member ID	Claim Number	CPT/HCPCs	Date of Service	Prior Payment	Estimated Amount Due

Reason(s for dispute:

INSTRUCTIONS

The following documentation MUST be submitted with this form:

1. Form 1500/UP04
2. Copy of Explanation of payment
3. Provider Contact information including name and address
4. Pricing information, including NPI Number (and CCN/OSCAR number for institutional providers), ZIP Code where services were rendered. Physician specialty
5. If available: any supporting documentation and correspondence that support your position that the payment is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare and similar or identical services)
6. Copy of the provider's submitted claim with disputed portion identified

Choose one of the methods below to submit your Dispute Request:

Mail to:
Appeals and Grievances Department
PO Box 71114,
San Juan, PR 00936-8014

Fax to:
(787)-625-3375

Important information:

The time frame for disputing a reimbursement issue to the MAO Plan is 120 days form the initial determination date.

Requests that do not contain all required elements are considered incomplete and subject to dismissal. Waiver of liability is not a requirement for the dispute process.

Every dispute is processed within 30 days from the receipt date.

If you have any question, please contact the Provider Relations Department at (787) 993-2317 (Metro Area) or 1-866-676-6060 (toll free) from Monday to Friday 7:30AM-6:00PM

PROVIDER SIGNATURE: _____ DATE: _____