PREFERRED CARE NETWORK
A UnitedHealthcare Company

Preferred Care Network 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 MedicareMax Medicare Advantage FL-0028 (HMO)
- UHC MedicareMax Medicare Advantage FL-0029 (HMO)
- UHC MedicareMax Complete Care FL-30 (HMO C-SNP)

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

Medical Care - Part C&B

- UHC MedicareMax Dual Complete FL-D4 (HMO D-SNP)
- UHC MedicareMax Dual Complete FL-V3 (HMO D-SNP)
- UHC MedicareMax Dual Complete FL-Y6 (HMO-POS D-SNP)

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

Prescription Drugs - Part D

- All plans

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