Triple S Advantage
PO Box 11320
San Juan, PR 00922

Waiver of Liability

_____
Medicare Identification Number

_____
Member's Name

_____ _____
Provider Date of Service

_____
Health Insurance

Hereby waive any right to collect any payment reference to secured by the aforementioned services, which payment has been denied by the health plan mentioned above. I understand that signing this liability waiver does not deny my right to request another appeal under 42 CFR 422,600.

_____ _____
Signature Date