<DATE>

<PROVIDER NAME>
<ADDRESS>
<CITY, STATE, ZIP CODE>

Regarding: <ENROLLEE NAME>
Member ID Number: <ENROLLEE ID>
Claim Number: <CLAIM #>
Date of Service: <DATE OF SERVICE
Total Billed Amount: <AMOUNT>

Dear Provider:

This letter is to notify you that your request for an appeal was received by KelseyCare Advantage on <appeal received date>.

In order to process your request for an appeal, Medicare requires that all non-participating providers complete a Waiver of Liability. Without a completed Waiver of Liability, your appeal will not be reviewed. Attached is a Waiver of Liability. Please complete and mail or fax form to:

KelseyCare Advantage
Attention: Appeals and Grievances Department
P.O. Box 841569
Pearland, TX 77584
Fax Number: 713-442-9536

Please submit this completed form within the 60-day appeal timeframe from the date of the appeal was received.

If you have any questions, please contact Member Services at 713-442-CARE (2273) or toll-free at 1-886-535-8343 (TTY: 711) from 8 a.m. to 8 p.m., seven days a week, from October 1 to March 31 and 8 a.m. to 8 p.m., Monday through Friday, from April 1 to September 30.

Thank you,

Appeals & Grievances
KelseyCare Advantage

Waiver of Liability Statement

Enrollee's Name	Enrollee ID Number/MBI
Provider's Name	Dates of Service
Health Plan	

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