SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.622.7790 | TTY 711

Non-participating Provider

Waiver of Liability

_____

Medicare number

_____

Member name

_____ _____/_____/_____

Provider name Date of service (m/d/y)

Security Health Plan of Wisconsin, Inc.

_____

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 of service (m/d/y)

Please complete and submit with your Formal Provider Appeal form to:

Security Health Plan of Wisconsin, Inc.
Attn: Claims Department Appeals
PO Box 8000
Marshfield, WI 54449-8000
Or fax to: 715-221-9650
Or email to: shp.claims.provider.appeals@securityhealth.org

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