

**Health First**  
Health Plans



**A Medicare Advantage Plan**

**PROVIDER WAIVER  
to initiate Medicare Advantage claim appeal**

\_\_\_\_\_  
**Member Name**

\_\_\_\_\_  
**Medicare/HIC Number**

\_\_\_\_\_  
**Provider Name**

\_\_\_\_\_  
**Date(s) of Service**

I hereby waive the right to collect payment from the above-mentioned enrollee on the aforementioned services for which payment has been denied by Health First Health Plans, Inc. I understand the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.582(d).

\_\_\_\_\_  
**Authorized Signature**

\_\_\_\_\_  
**Date**