Santa Clara Family Health Plan™

Waiver of Liability Statement

Fax Number: 1-408-874-1962

Waiver of Liability (WOL) only applies to non-contracted providers for Cal MediConnect members. Non-contracted providers must include a signed Waiver of Liability form when filing a claims appeal.

Please fill in the fields below and fax to the attention of: SCFHP Appeals and Grievances Department: **1-408-874-1962**.

Medicare/HIC Number:_____

Enrollee's Name:_____

Provider:_____

Date(s) 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:_____