GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

WAIVER OF LIABILITY STATEMENT

I hereby waive any right to collect payment from the above-mentioned enrollee for the 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.

Provider's Signature: _____ Provider's Tax ID Number: _____

Provider Telephone Number: _____ Date: _____

Total Care Advantage
Attention: Claims
P.O. Box 9152
Oxnard, CA 93031-9152
Fax: (844) 847-2892
Email: ProviderRelations@goldchp.org