CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
TTY: 711
caloptima.org

Waiver of Liability Statement

Enrollee's Name _____ Enrollee ID Number _____

Provider _____ Dates of Service _____

CalOptima Health (Orange County Health Authority) _____

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 _____