WAIVER OF LIABILITY STATEMENT

_____

Medicare/HIC Number

_____

Enrollee's Name

_____ _____

Provider *Dates 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*