brand new day

HEALTHCARE YOU CAN FEEL GOOD ABOUT

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.

_____

Name and title (Printed)

_____

Signature

_____

Date