EyeMed Vision Care
Provider Relations
4000 Luxottica Place
Mason OH 45040

Waiver of liability statement

_____
Medicare/HIC Number

_____
Enrollee's Name

_____
Enrollee's Member ID

_____
Enrollee's Date of Birth

_____ _____
Provider Name 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