



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 member 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 44.600.

Signature

Date