



***Waiver of Liability Statement***

\_\_\_\_\_  
*Enrollee's Name*

\_\_\_\_\_  
*Medicare/HIC Number*

\_\_\_\_\_  
*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*