



Waiver of Liability Statement

Click or tap here to enter text.

Enrollee's Name

Click or tap here to enter text.

Enrollee ID Number

Click or tap here to enter text.

Provider

Click or tap here to enter text.

Dates of Service

Click or tap here to enter text.

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