UnitedHealthcare®
Medicare Solutions

WAIVER OF LIABILITY STATEMENT

Member Name: _____ Medicare No: _____

UnitedHealthcare Member ID Number: _____

Care Provider Name: _____ Date of Service: _____

I hereby waive any right to collect payment from the above-mentioned member for the aforementioned services for which payment has been denied. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature	Date
Print Name	Title

Please send this completed form (and other appropriate documentation, if applicable) to the address on the Provider Remittance Advice (PRA). Thank you.