Waiver of Liability Statement

Member / HIC Number
Enrollee's Name
Provider
Date 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: _______________________