**Waiver of Liability Statement**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Medicare/HIC Number

 Enrollee’s Name Enrollee ID 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