Waiver of Liability Statement

~~Enrollee Name~~ ~~Enrollee ID Number~~

~~Provider~~ ~~Dates of Service~~

_____
Health Plan

By signing below, I give up ("waive") any right to collect payment from the enrollee (above) for the item, service or Part B drug furnished to the enrollee that the enrollee's health plan has denied. I understand that signing this waiver doesn't negate my right to appeal under 42 CFR §422.600.

_____ _____
Signature Date