WAIVER OF LIABILITY STATEMENT

Enrollee's 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