



## 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