MEDICARE MANAGED CARE RECONSIDERATION PROJECT

WAIVER OF LIABILITY STATEMENT

_____ _____

Enrollee Name **Medicare/HIC 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**