

## Waiver of Liability Statement

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