



## Waiver of Liability Statement

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Enrollee's Name

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Enrollee ID Number

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Provider

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Dates of Service

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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.

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Signature

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Date