

# Waiver of Liability Statement

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Enrollee 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

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.

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Signature

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Date