Waiver of Liability Statement

Enrollee's Name

Enrollee ID Number

Appeal ID

Provider

Date(s) 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

H6396_OH-SNP-P-3934779_C