Select Health

# WAIVER OF LIABILITY STATEMENT

Medicare / HIC Number

Enrollees name

Provider

Dates of service

Health plan

I hereby waive any right to collect payment form 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