Waiver of Liability Statement

Enrollee Name _____ Enrollee ID Number _____

Provider _____ Dates of Service _____

Dental 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 _____