

Waiver of Liability Statement

Medicare/HIC Number

Enrollee's Name

Provider

Date(s) of Service

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.

Signature

Date

*Please reference Medicare Managed Care Manual Chapter 13 section 70.1 (Rev. 80, Issued: 03-03-06, Effective Date: 03-03-06) which states:

“When a non-contracted physician or provider seeks a standard reconsidered determination for purposes of obtaining payment only, then the non-contracted physician or provider must sign a waiver of liability, i.e., the non-contracted physician or provider formally agrees to waive any right to payment from the enrollee for a service.”

**Without this form, the case will be dismissed by the IRE and no appeal will take place.