Waiver of Liability Statement

Section 1 – Enrollee Information

First Name ______ MI ______ Provider Name ______

Last Name ______ Suffix ______ Beginning Date of Service ____/____/____ Ending Date of Service ____/____/____

Enrollee ID Number ______ Health Plan ______

Section 2 – Authorization

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.

Your signature required

Signature of Provider ______ Date Signed ____/____/____

Print Name ______

An independent licensee of the Blue Cross Blue Shield Association.