Health Net® MHN Provider Appeals &
Disputes Unit - Medicare Programs
P.O. Box 419105
Rancho Cordova, CA 95741-9105
Phone 1-800-444-4281
Fax 1-916-935-4511
TTY/TDD: 1-800-977-6757
Hours of operation:
8:00 a.m. to 8:00 p.m.
www.healthnet.com
www.mhn.com

MEDICARE MANAGED CARE RECONSIDERATION PROJECT

WAIVER OF LIABILITY STATEMENT

_____ _____
Enrollee Name Medicare/HIC Number

_____ _____
Provider Dates 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**