Health Net® Medicare Programs
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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**