



18000 Studebaker Rd, Ste 960
Cerritos, CA 91755

WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee's Name

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