Waiver of Liability Statement
Form

ENROLLEE'S FIRST NAME		ENROLLEE'S LAST NAME	
MEMBER ID NUMBER	MEDICARE NUMBER	DATE OF SERVICE	HEALTH PLAN Ultimate Health Plans, Inc.
PROVIDER NAME			

By signing below, I give up ("waive") any right to collect payment from the enrollee (above) for the item, service or Part B drug furnished to the enrollee that the enrollee's health plan has denied. I understand that signing this waiver doesn't negate my right to appeal under 42 CFR §422.600.

PROVIDER SIGNATURE

DATE