Prominence®
Health Plan

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