Hill Physicians
Your health. It's our mission.

WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number

Enrollee's Name (Please Print)

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