SeretisCare Family Practice

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MEDICAID / MEDICARE WAIVER OF LIABILITY STATEMENT

Enrollee's Name _____

Medicare HIC Number _____

Provider _____

Date _____

Health Plan _____

ID Number _____

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.

_____ _____

Patient Signature Date