WAIVER OF LIABILITY STATEMENT

for AvMed Medicare Choice

_____ _____

Medicare Number **Provider Name**

_____ _____

Enrollee's Name **Dates of Service**

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