IEHP DualChoice (HMO D-SNP) Plan
(Medicare – Medicaid Plan)

WAIVER OF LIABILITY STATEMENT

Enrollee Name	Medicare/HIC Number
Provider	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