MEDICA®

Medicare Waiver of Liability Statement

Medicare/Health Insurance Claim Number
(HIC #)

Enrollee's Name

Provider

Dates of Service

Medica
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 Medica. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature

Date