Provider Waiver of Liability Statement

Member Name:	Inquiry Number:
Member ID Number:	Provider Name:

I/We hereby request an appeal on behalf of the member named above. This appeal asks that you reconsider your decision to decline coverage of the services received by the member on _____/_____/_______.

If the appeal decision does not authorize coverage of these services, we waive any and all rights to hold the member responsible for any payment for services provided. I/We understand that the signing of this waiver does not negate my/our right to request further appeal under 42 CFR 422.600.

Provider Information:

Provider Signature:	Date: _____/_____/________
Tax Identification Number:	Phone Number: (______)______-_________

Provider Navigators are available to answer any questions you may have, so don't hesitate to reach out if you need anything. You can reach a Provider Navigator at 1-833-502-2013, 8 AM to 5 PM Eastern time, Monday through Friday.

Author by Humana