aetna[SM]

P.O. Box 14067
Lexington, KY 40512
Telephone: 1-800-624-0756
Fax: 860-754-0547

WAIVER OF LIABILITY STATEMENT

_____
Medicare/HIC Number

_____
Enrollee's Name

_____ _____
Provider Dates of Service

_____
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 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