EmblemHealth®

WAIVER OF LIABILITY STATEMENT

EmblemHealth Grievance and Appeal Department – 2nd Floor

SR#:

Enrollee's Name:	Medicare/HIC Number:
Provider:	Dates of Service:
Health Plan: **EmblemHealth**	

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: