Health Net
LIFE INSURANCE COMPANY

MEDICARE WAIVER OF LIABILITY STATEMENT

_____	_____
Patient Name	Health Net Subscriber ID Number
_____	_____
Provider Name (Please Print)	Provider Tax ID Number

_____
Service "From/To" Date

Health Net Life Insurance Company
Health Plan

I hearby waive any right to collect payment from the above-mentioned patient 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
_____	_____
Print Name	Telephone Number with Area Code