ULTIMATE
HEALTH PLANS
www.ChooseUltimate.com

Waiver of Liability Statement

ENROLLEE'S FIRST NAME		ENROLLEE'S LAST NAME	
MEMBER ID NUMBER	MEDICARE NUMBER	DATE OF SERVICE	HEALTH PLAN Ultimate Health Plans, Inc.
PROVIDER			

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