MEDICAL MUTUAL

Waiver of Liability Statement

Member Information:			
Last Name	First Name	MI	Birthdate
Health Plan	Member ID Number		
Dates of Service			
Provider Information:			
Provider Name	Phone Number	NPI	
Authorization:			
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.			
Provider Signature	Date		

Please complete all sections above. Be sure to sign and date the completed form. You can fax the completed form to (844) 606-5394 or mail it to:

Member Appeals Department
P.O. Box 94563
Cleveland, OH 44101-4563