Community HealthFirst™
Medicare Advantage Plans

Offered by COMMUNITY HEALTH PLAN of Washington™

WAIVER of LIABILITY STATEMENT

_____
Medicare/HIC Number

_____
Enrollee's Name

_____ _____
Provider Dates of Service

Community Health Plan of Washington (HMO)

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)