Waiver of Liability Statement

Member Information:			
Last Name	First Name	MI	Birthdate
Health Plan	Member ID Number		
Date(s) of Service			

Provider Information:		
Provider Name	Phone Number	NPI Number

Authorization:	
By signing below, I give up (“waive”) any right to collect payment from the enrollee (above) for the item, service or Part B drug furnished to the enrollee that the enrollee’s health plan has denied. I understand that signing this waiver doesn’t negate my right to appeal under 42 CFR §422.600.	
Provider Signature	Date

Please complete all sections above. Be sure to sign and date the completed form. You may fax the completed form to 812-401-4557 or mail to:

HRI Dental & Vision
Non-Contracted Provider Appeals
PO Box 659
Evansville, IN 47704

Office use only:	
Date Received	Initials
Date Submitted to Health Plan	Initials