Partners Health Plan

Waiver of Liability Statement for

Appeal by FIDA Non-Participating Provider

_____

Participant ID number

_____

Claim ID Number

_____

Participant Name

_____ _____

Provider Name Dates of Service

_____

Name of FIDA Plan

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 Medicare rules.

_____ _____

Signature Date

_____

_____

Name and position of person signing