



**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