



Wellcare By Health Net - Appeals  
P.O. Box 3060  
Farmington, MO 63640-3822  
Healthnet.com

**MEDICARE MANAGED CARE RECONSIDERATION PROJECT**  
**WAIVER OF LIABILITY STATEMENT**

\_\_\_\_\_  
Enrollee Name

\_\_\_\_\_  
Medicare Beneficiary Identifier (MBI) Number

\_\_\_\_\_  
Provider

\_\_\_\_\_  
Dates of Service

\_\_\_\_\_  
Health 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 42 CFR §422.600.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date