AmeriHealth NEW JERSEY

Waiver of Liability Statement

Medicare/HIC Number:
Enrollee's Name:
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.	
X_____ Signature	_____ Date