WAIVER OF LIABILITY STATEMENT

ConnectiCare Grievance and Appeal Department – 2nd Floor
SR# _____

_____ _____
Enrollee's Name Medicare/HIC Number

_____ _____
Provider Dates of Service

ConnectiCare
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