ATRIO™
HEALTH PLANS

WAIVER OF LIABILITY STATEMENT

Medicare/HIC Number: _____

Enrollee's Name: _____

Provider: _____

Dates of Service: _____

Health Plan: ATRIO Health Plans

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: _____