

**Waiver of Liability Statement for
Appeal by MAP Non-Participating Provider**

Case Number:

Member ID number

Member Name

Provider Name

Dates of Service

Name of MAP 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