Waiver of Liability Statement for

Appeal by MAP Non-Participating Provider

Case Number:

_____
Member ID number

_____
Member Name

_____ _____
Provider Name Dates of Service

VNSNY CHOICE Total
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