Humana®

Humana Waiver of Liability Statement

Inquiry #: _____

Member's Name	**Medicare Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)**
Provider's Name	**Date(s) of Service**
Humana **Health Plan**	**Humana ID Number**

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.

Provider Signature	**Tax Identification Number**
Telephone Number	**Date**