Humana®

Waiver of Liability Statement

Inquiry number: _____

_____ _____
Member name Humana ID no.

_____ _____
Medicare Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI) Provider name

_____
Date(s) of service

I/we hereby waive any right to collect payment from the above-mentioned patient for the aforementioned services for which Humana has denied payment. 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

_____ _____
Phone number Date