COMMUNITY HEALTH CHOICE

Waiver of Liability Statement

Enrollee's Name _____ Enrollee ID Number _____

Provider _____ Dates of Service _____

Community Health Choice (HMO D-SNP)
Health 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 42 CFR §422.600.

Provider Signature _____ Date _____