WAIVER OF LIABILITY STATEMENT

Enrollee's Name _____ Medicare/HIC Number _____

Provider _____

Health Plan Vibra Health Plan Date of Service _____

I hereby waive any rights 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 rights to request further appeal under 42 CFR 422.600.

Signature _____ Date _____