



**NON-PARTICIPATING PROVIDER  
WAIVER OF LIABILITY STATEMENT**

Carelon Post Acute Solutions Claim #:

Enrollee's Name:	Member ID:
Provider:	Dates of Service:
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.

Signature:	Date:
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