2805 Veterans Memorial Hwy, Suite 17
Ronkonkoma, NY 11779
Telephone (Toll Free): 1-877-233-7058
FAX: 877-738-4870
TTY/TDD: 711

WAIVER OF LIABILITY STATEMENT

_____
Member ID/Medicare Number

_____
Enrollee's Name

_____ _____
Provider Dates of Service

QUALITY HEALTH PLANS OF NEW YORK__
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