Health First
Health Plans

6450 US Highway 1
Rockledge, Florida 32955
myHFHP.org

Waiver of Liability Statement

Enrollee's Name _____

Provider _____

Medicare/HIC Number _____

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 _____

10/2017