Waiver of Liability Statement for Out-of-Network Providers

Health Plan: PHP (HMO SNP)

Enrollee Name:_____ Enrollee ID: _____

Provider Name:_____ Date of Service: _____

Services Rendered:_____

_____

_____

_____

By signing below, I give up ("waive") any right to collect payment from the enrollee (above) for the item, service or Part B drug furnished to the enrollee that the enrollee's health plan has denied. I understand that signing this waiver doesn't negate my right to appeal under 42 CFR §422.600.

_____

Print Provider/Provider Representative Name

_____ _____

Provider/Provider Representative Signature Date

Send completed form to:

Attn: Claims Operations
PHP
1710 N. La Brea Blvd.
Los Angeles, CA 90046-3010