Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)

Health Net Community Solutions, Inc.
Attn: Appeals & Grievances Dept.
P.O. Box 10422
Van Nuys, CA 91410-0422

Waiver of Liability Statement

_____ _____
Enrollee's Name Enrollee ID Number

_____ _____
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 42CFR §422.600

_____ _____
Signature Date