

**Waiver of Liability Statement for
Appeal by FIDA Non-Participating Provider**

Participant ID number

Claim ID Number

Participant Name

Provider Name

Dates of Service

Name of FIDA 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 Medicare rules.

Signature

Date

Name and position of person signing