



Medical Associates Health Plans (MAHP) Waiver of Liability Statement

Member's Name _____

MAHP Member's ID _____

Provider Name _____

Health Plan Medical Associates Health Plans _____

Date(s) of Service _____

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.

Provider Signature _____

Date _____