PARAMOUNT

Waiver of Liability Statement

Member Information:			
Last Name	First Name	MI	Birthdate
Health Plan	Member ID Number		
Date(s) of Service			

Provider Information:		
Provider Name	Phone Number	NPI

Authorization:	
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.	
Provider Signature	Date

Please complete all sections above. Be sure to sign and date the completed form. You can fax the completed form to 567-585-9500 or mail it to:

Paramount
Non-Contracted Provider Appeals
P.O Box 497
Toledo, OH 43697-0497