Waiver of Liability (WOL) Statement

**Please provide if an appeal case has already been opened to facilitate the WOL being attached to the case.*

***SCAN Appeal Number**

Enrollee's Name

SCAN Enrollee ID Number

Provider's Name

Date of Service

SCAN HEALTH PLAN

Health Plan

Medicare HIC Number (HICN) or Medicare Beneficiary Identifier (MBI)

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 CRF §422.600.

Provider Signature

Date (MM/DD/YYYY)

Phone Number (xxx) xxx-xxxx

Tax Identification Number (TIN)