WAIVER OF LIABILITY STATEMENT

Member's Name: ____

Member's ATRIO ID Number: ____

Provider: ____

Dates of Service: ____

Health Plan: ATRIO Health Plans

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.

Signature: ____________________________________ Date: _______________________

03/16

MAIN OFFICE: 2270 NW Aviation Drive Suite 3, Roseburg, OR 97470 | PHONE: (877) 672-8620 | FAX: (541) 672-8670