## WAIVER OF LIABILITY STATEMENT

## ConnectiCare Grievance and Appeal Department – 2nd Floor SR# \_\_\_\_\_

Enrollee's Name	Medicare/HIC Number
Provider	Dates of Service
ConnectiCare Health Plan	
aforementioned services for which payment	ayment from the above-mentioned enrollee for the thas been denied by the above-referenced health plan. I bees not negate my right to request further appeal under 42
Signature	Date