Waiver of Liability (WOL) Statement

Member Name	
Medicare Number	
Troy Medicare Member ID	
Provider Name	
Date of Service	

I hereby waive any right to collect payment from the above-mentioned member for the aforementioned services for which payment has been denied. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

Signature	
Date	
Title	
Phone Number	

Please send this completed form (and other appropriate documentation) to:

Troy Medicare
Attention: Provider Appeals
Fax# 910.839.8320
Or mail to
PO Box 1265
Westborough, MA 01581

A provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which states that the provider will not bill the enrollee regardless of the outcome of the appeal. Please submit this Waiver of Liability, along with documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the request for reimbursement, within 60 calendar days from the remittance notification date to file for reconsideration of the denial of payment.