MOLINA HEALTHCARE

Your Extended Family.

Waiver of Liability (WOL) Statement

Member Name: _____Medicare/HIC Number_____

Molina Dual Options Medicare-Medicaid Plan Member ID Number:
_____

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

_____ _____

Print Name Title

Please attach this completed form (and other appropriate documentation, if applicable) when submitting a dispute via Molina Healthcare's portal or please include this completed form when submitting a dispute via fax. Thank you.