Humana.

P.O. Box 14546
Lexington, KY 40512-4546

PROVIDER RECONSIDERATION WAIVER

Provider Name _____ **Health Plan** _____

Member Name _____ **Member ID Number** _____

Address:_____ **Phone**: _____

_____

_____

I/We hereby request reconsideration (appeal) regarding the above-mentioned member for services incurred on _____.

If the reconsideration (appeal) determination is adverse, I/we waive any and all rights to hold the above-mentioned member responsible for any payment of services provided. I/We understand that the signing of this waiver does not negate my/our right to request further appeal under 42 CFR 422.600.

Provider Signature _____ **Tax Identification Number** _____

Telephone Number _____ **Date** _____