Beneficiary Waiver of Liability for Medical Expenses

Date: [Insert Date]

To Whom It May Concern,

I, [Beneficiary Name], with the identification number [ID/SSN], hereby acknowledge and agree to waive any and all claims for medical expenses incurred as a result of my treatment or care received from [Provider's Name] at [Facility Name].

I understand that by signing this waiver, I am relinquishing my right to seek reimbursement or compensation for any medical expenses that may arise in the future related to this treatment.

This waiver is effective as of [Effective Date] and will remain in effect until revoked in writing.

Signature: _____

Printed Name: [Beneficiary Name]

Date: _____

If you have any questions regarding this waiver, please contact [Your Contact Information].

Thank you.