



Privacy Policy

Last updated: MONTH XX, 2021

The Centers for Medicaid and Medicare Services (CMS) ("us", "we", or "our") operates <http://www.cms.gov/nosurprises> (the "Site"). This page informs you of our policies regarding the collection, use and disclosure of Personal Information we receive from users of this form.

By using the No Surprises Complaint form (form), you agree to the collection and use of information in accordance with this policy.

Information Collection And Use

While using our form, we may ask you to provide us with certain personally identifiable information that can be used to contact or identify you. Personally identifiable information (PII), defined by the Office of Management and Budget (OMB), refers to information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

When you fill out this form:

After you submit a complaint, your personal information may be disclosed to other federal agencies as they may have jurisdiction authority to review and investigate your complaint, if applicable. These organizations may include the U.S. Office of Personnel Management (OPM), the Treasury Department (Treasury), and the U.S. Department of Labor (DOL).

In accordance with the Privacy Act of 1974, a system of records has been created for the collection of personally identifiable information you submit on this form. The original system of records notice entitled, "No Surprises Complaint Form" was published in the Federal Register on MONTH XX, 2021.

The system of records and modifications can be found at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/CMS-Systems-of-Records.html>.

For specific details on the data collected by the systems that make up the form, please view the Privacy Impact Assessments (PIA) located at: <http://www.hhs.gov/pia/>.

Log Data

Like many site operators, we collect information that your browser sends whenever you visit our Site ("Log Data").



This Log Data may include information such as your computer's Internet Protocol ("IP") address, browser type, browser version, the pages of our Site that you visit, the time and date of your visit, the time spent on those pages and other statistics.

CMS will keep data collected long enough to achieve the specified objective for which they were collected. Once the specified objective is achieved, the data will be retired or destroyed in accordance with published draft records schedules of CMS as approved by the National Archives and Records Administration.

CMS does not store information from cookies on CMS systems. CMS assesses whether the expiration date of a cookie exceeds one year and provides an explanation as to why cookies with a longer life are used on the site in the associated Third-Party Website or Application Privacy Impact Assessment. These explanations can be found at <http://www.hhs.gov/pia#Third-Party>.

Communications

We may use your Personal Information to contact you if we need more information or documentation, or to notify you of the resolution to your complaint. We may contact you by phone and/or email, dependent on the contact information that you provided to us.

Cookies

Cookies are files with small amount of data, which may include an anonymous unique identifier. Cookies are sent to your browser from a web site and stored on your computer's hard drive.

Like many sites, we use "cookies" to collect information. You can instruct your browser to refuse all cookies or to indicate when a cookie is being sent. However, if you do not accept cookies, you may not be able to use some portions of our Site.

Security

The security of your Personal Information is important to us, but remember that no method of transmission over the Internet, or method of electronic storage, is 100% secure. While we strive to use commercially acceptable means to protect your Personal Information, we cannot guarantee its absolute security.

Changes To This Privacy Policy

This Privacy Policy is effective as of **MONTH XX, 2021** and will remain in effect except with respect to any changes in its provisions in the future, which will be in effect immediately after being posted on this page.

We reserve the right to update or change our Privacy Policy at any time and you should check this Privacy Policy periodically. Your continued use of the Service after we post any modifications to the



Privacy Policy on this page will constitute your acknowledgment of the modifications and your consent to abide and be bound by the modified Privacy Policy.

If we make any material changes to this Privacy Policy, we will notify you either through the email address you have provided us, or by placing a prominent notice on our website.

Contact Us

If you have any questions about this Privacy Policy, please contact us.

No Surprises Consumer Complaint form

* **Indicates a required field**

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| Document Submission |
| Are you submitting documentation for a previous complaint? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Please provide your ticket number _____ I don't have it. <input type="checkbox"/> |
| Complaint Type |
| I am reporting a violation against a/an: |
| <input type="checkbox"/> Provider |
| <input type="checkbox"/> Air-ambulance provider |
| <input type="checkbox"/> Health Care Facility |
| <input type="checkbox"/> Insurance Company or Plan (Select One*): |
| <i>What type of coverage or plan is this?</i> |
| <input type="checkbox"/> Non-Federal Governmental Plan |
| <input type="checkbox"/> Self-funded group health plan from a private employer |
| <input type="checkbox"/> Fully-insured group health plan from private-sector employer |
| <input type="checkbox"/> Federal Employees Health Benefits (FEHB) Plan |
| <input type="checkbox"/> Individual Health Insurance Plan outside the Health Insurance Marketplace |
| <input type="checkbox"/> Health Insurance Marketplace Plan |
| Marketplace Application ID _____ |
| <input type="checkbox"/> State-Based Marketplace |
| <input type="checkbox"/> Medicaid or the Children's Health Insurance Program (CHIP) |
| <input type="checkbox"/> Faith-Based Plan |
| <input type="checkbox"/> TRICARE |
| <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other |
| Complaint Category |
| <input type="checkbox"/> Emergency services (including inpatient physician or hospital services after emergency room visit): You visited an emergency room and the hospital and/or provider(s) were out-of-network and you were charged more than you think you should have been charged. |
| <input type="checkbox"/> Scheduled non-emergency services at an in-network hospital or ambulatory surgical center: You received services at an in-network hospital or an ambulatory surgical center and were charged |

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| more than you think you should have been by an out-of-network provider at the facility. |
| <input type="checkbox"/> Disclosure of Patient Protections: Your provider or health care facility did not disclose (e.g., display a sign, post on website) patient protections against balance billing. |
| Do you wish to submit your complaint anonymously? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Continuity of Care: You were not told that your provider has left the network or you were not charged in-network cost (i.e., deductible, copayment, coinsurance) for up to 90 days after the provider left the network. |
| <input type="checkbox"/> Mental Health Parity and Addiction Equity Act (MHPAEA): Your health insurance company or plan is not following a protection provided to you under MHPAEA. |
| For uninsured or self-pay consumers: |
| <input type="checkbox"/> Patient Provider Dispute Resolution (PPDR): You are uninsured or a self-pay individual, and eligible for the PPDR process, and you believe your provider or facility is not complying. |
| <input type="checkbox"/> Advanced Cost Information: You are uninsured or a self-pay individual, and were not given upfront information (also known as a “good-faith estimate”) on costs ahead of a service or there is a difference between the information provided to you and the actual amount you were charged. |
| <input type="checkbox"/> I have a complaint related to the No Surprises Act that is not listed above. |

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| Contact Information |
| Are you reporting a violation on behalf of someone else? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Name: |
| Telephone Number: |
| Email: |
| Name: |
| Address: |
| City: |
| State: |
| Zip: |
| Telephone Number |
| Email: |
| Do you prefer to be contacted by: Telephone <input type="checkbox"/> Email <input type="checkbox"/> |
| Insurance Company/Plan Information |
| Are you insured? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> |
| Name of Health Insurance Plan or Company (at time of violation): |
| Policy or ID # |
| Group Number: _____ N/A <input type="checkbox"/> |
| Claim Numbers: _____ |
| CPT Codes: _____ |
| Employer/Union Information (If Job-Based Coverage) |

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| Employer/Union Name: |
| Employer/Union Telephone Number (Human Resources): _____ |
| Policyholder information (if different than above) |
| Name of policyholder: |
| Address: |
| City: |
| State: |
| Zip: |
| Telephone Number: |
| Email: |

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| Medical provider, Air-Ambulance Provider, and/or Health care facility Information |
| Click all that apply: Provider <input type="checkbox"/> Air-Ambulance Provider <input type="checkbox"/> Health Care Facility <input type="checkbox"/> |
| Provider/Air-Ambulance Provider Name: |
| Address: |
| City: |
| State: |
| Zip: |
| Telephone Number: |
| Email: |
| Provider/Air-Ambulance Provider Employer Identification Number (EIN): |
| Provider/Air-Ambulance Provider National Provider Identifier (NPI) |
| <input type="checkbox"/> In-Network Provider <input type="checkbox"/> Out-of-Network Provider |
| Name of Health Care Facility: |
| Address: |
| City: |
| State: |
| Zip: |
| Telephone Number: |
| Email: |
| Facility Specialty Type: |
| Health Care Facility Employer Identification Number (EIN): |
| Health Care Facility National Provider Identifier (NPI) |
| <input type="checkbox"/> In-Network Health Care Facility <input type="checkbox"/> Out-of-Network Health Care Facility |

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| Explain the specific problem you are having |
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| [Free Text] |
| State where service was received (if different from current address) |
| State _____ |
| Date(s) of Service Related to the Complaint |
| [Free Text] |
| Action(s) Previously Taken to Resolve |
| [Free Text] |

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| Documentation |
| <i>Please submit applicable supporting documentation below. Failure to provide supporting documentation may prevent us from investigating your complaint.</i> |
| <input type="checkbox"/> Notice and Consent form(s) (Signed and Dated) |
| <input type="checkbox"/> Advanced Cost Information (also known as a “Good Faith Estimate”) |
| <input type="checkbox"/> Bill(s) from plan, issuer, provider, air ambulance provider, or health care facility |
| <input type="checkbox"/> Correspondence |
| <input type="checkbox"/> Explanation of Benefits received from your health plan or insurer (for date of service) |
| <input type="checkbox"/> Notices of Appeal decision(s) |
| <input type="checkbox"/> Front and back of health insurance card |
| <input type="checkbox"/> Claim(s) |
| <input type="checkbox"/> Evidence of Coverage (Examples - Summary plan description, Policy, Certificate, Contract of insurance, Membership booklet, or Outline of coverage) |
| <input type="checkbox"/> Other |

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| Demographic Information (Optional) |
| Consumer Ethnicity |
| Are you Hispanic or Latino? Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> |
| Consumer Race |
| <i>One or more categories may be selected:</i> |
| <input type="checkbox"/> White |
| <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian |
| <input type="checkbox"/> Prefer not to answer |
| Consumer Age: |
| Consumer Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> |

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| Declaration |
| By filling in my name and date below, I declare the information contained on this form is true and accurate. |
| Name: |
| Signature: |
| Nature of Representation (Parent, Guardian, Power of Attorney, etc.): |
| Date: MM/DD/YYYY |

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| Submit |
| Once you've completed this form and attached supporting documentation, please click on the Submit button below: <input type="button" value="SUBMIT"/> |
| Questions? Call the No Surprises Help Desk at: 1-800-985-3059 https://www.cms.gov/nosurprises |