

APPENDIX 4

## Patient-Provider Dispute Resolution Form

### Find out if you qualify for the dispute resolution process

This form is only for people who do <b>not</b> have health insurance or who decided not to use insurance for their medical care.		
Did your health care provider give you a Good Faith Estimate for the item or service?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the bill for your health care provider at least \$400 more than the Good Faith Estimate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the <b>date on the top of the bill</b> within the last 120 calendar days (about 4 months)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answered **NO** to any of these questions:

- You do not qualify for the dispute resolution process. Please contact your health care provider to negotiate your bill and ask for financial assistance.
- If you think you should have been given a Good Faith Estimate or have other questions, please visit [www.cms.gov/nosurprises](http://www.cms.gov/nosurprises) or call [insert HHS number]

If you answered **YES** to **ALL** of these questions:

**You qualify for the dispute resolution process. Please complete the rest of this form.**

Note: While the dispute resolution process is happening, you can still ask your health care provider for a lower bill.

<b>Patient name (and Authorized Representative name, if needed)</b>		
Patient First Name	Middle Name	Last Name
<b>(Optional) If you are filling out this form for the patient, please print your name:</b>		
<input type="checkbox"/> Check this box if you are an Authorized Representative and should be contacted instead of the patient. Write <b>your</b> information in the “mailing address and phone number” section.		
Note: This is common for patients under age 18 or patients who need help completing medical forms.		
<b>Mailing Address and Phone Number</b>		
Street or PO Box	<b>Apartment</b>	
City	State	ZIP
Phone		
<b>Details about the medical item or service you want to dispute</b>		
The State where the patient received the item or service:		
The date when the patient received the item or service:		
Month	Day	Year

Write a short description of the item or service you want to dispute. (For example, “knee replacement” or “cervical cancer screening”)

**I have included with this form:**

A copy of the bill from my health care provider that I want to dispute

A copy of the Good Faith Estimate for the item or service that I want to dispute

**Contact information for the health care provider that provided the item or performed the service. This should be on your Good Faith Estimate.**

Health Care Provider Name

Hospital, Facility, or Group Name

Street

City

State

ZIP

Email

Phone

**Read and sign**

- I agree to let my health care provider to release all relevant medical or treatment records related to this dispute, to a Selected Dispute Resolution (SDR) entity and selected by the U.S. Department of Health and Human Services (HHS). I understand the SDR entity will only use this information to make a decision on this dispute. My information will be kept confidential and not released to anyone else. If this information is still needed after 1 year, I will be asked to release my information again.
- I agree to pay a \$25 fee for the dispute process.
- When the SDR entity makes the decision about the price for these medical items or services, I agree to pay the decided amount.

Check here to agree

Signature

Date

Print Name

## How to send this form

Make sure you have included:

- A copy of the **bill** from your health care provider or facility that you want to dispute
- A copy of the **Good Faith Estimate** for the item or service that you want to dispute

You can send this form and documents:

- **Online**  
[www.cms.gov/nosurprises](http://www.cms.gov/nosurprises)
- **By email**  
[HHS email]
- **By mail**  
[SDR entity name]  
Address  
Address

For additional help call [HHS phone] or e-mail [\[HHS email\]](#)

When HHS receives this form, they will send you a link where you can pay the fee to start the dispute process.

**Keep a copy or take pictures of this completed form. You may need it later.**

For more information about your right under federal law to dispute medical bills, visit:  
[www.cms.gov/nosurprises](http://www.cms.gov/nosurprises)