OMB Control Number XXXX-XXXX
Expiration Date MM/DD/YYYY

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 **not** 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 ☐	No ☐
Is the bill for your health care provider at least $400 more than the Good Faith Estimate?	Yes ☐	No ☐
Is the **date on the top of the bill** within the last 120 calendar days (about 4 months)?	Yes ☐	No ☐

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 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.

Patient name (and Authorized Representative name, if needed)		
Patient First Name	Middle Name	Last Name
(Optional) **If you are filling out this form for the patient, please print your name:** [ ] Check this box if you are an Authorized Representative and should be contacted instead of the patient. Write **your** 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.		
Mailing Address and Phone Number		
Street or PO Box		**Apartment**
City	State	ZIP
Phone		
Details about the medical item or service you want to dispute		
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

- **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