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

APPENDIX 8

Standard Notice: Selected Dispute Resolution (SDR) Determination Notice to Parties Provided Under the No Surprises Act

(For use by SDR Entities beginning January 1, 2022)

Instructions

Under Section 2799B-7 of the Public Health Service Act, the Department of Health & Human Services (HHS) is required to establish a patient-provider dispute resolution process for a SDR entity to resolve payment disputes between individuals who are not enrolled in a plan or coverage or a Federal health care program, or who are not seeking to file a claim with their plan or coverage, and health care provider or health care facility when the uninsured individual is billed for items and services substantially in excess of the "Good Faith Estimate" and the uninsured (or self-pay) individual initiates the patient-provider dispute resolution process within 120 calendar days of the provision of such items and services.

This notice is to be used by the selected SDR entities to notify the uninsured (or self-pay) individual and the health care provider or health care facility whether the difference between the billed amount and the "Good Faith Estimate" is justified or not and what amount the uninsured individual is to pay the health care provider or health care facility.

HHS has developed this model notice so that providers or facilities and uninsured (or self-pay) individuals are informed of the SDR entity's determination. To use this model notice, the SDR entity, must fill in the blanks with the appropriate information. HHS considers use of the model notice to be good faith compliance.

NOTE: The information provided in these instructions is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Readers should refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-XXXX. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Selected Dispute Resolution (SDR) Entity Decision Notice to Patient

Date

Patient or Authorized Representative Name
Patient or Authorized Representative Address
Patient or Authorized Representative City, State, Zip

RE: Patient-provider dispute process decision re: Reference Number: XXXXXXXX

[Patient or Authorized Representative Name],

We have reviewed the information for [Reference Number: XXXXXXXX]. Based on our review, our decision is that [health care provider or facility name] [select one: has OR has **not**] provided enough evidence to demonstrate the difference between the amount billed and the Good Faith Estimate is medically justified and based on unforeseen circumstances that could not have been reasonably anticipated.

Based on this decision, **[patient name] must pay [select one: $XXX, which is the total expected charges from the Good Faith Estimate** minus the $25 administration fee that you paid **OR $YYY, which is the billed charge OR $ZZZ, which is the median amount for the same or similar services by a same or similar provider in your geographic area]**. [Patient name] must directly pay [health care provider or facility].

This decision is binding, unless there are claims of fraud or a misrepresentation of facts presented to us, in which case you may have the right to other legal remedies. For more information, see www.cms.gov/nosurprises.

Sincerely,

[SDR entity name and contact information]

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

Selected Dispute Resolution (SDR) Entity Decision Notice to Health Care Provider or Facility

Date

Health Care Provider or Facility Name
Health Care Provider or Facility Address
Health Care Provider or Facility City, State, Zip

RE: Patient-provider dispute process decision re: Reference Number: XXXXXXXX

[Health Care Provider or Facility],

We have reviewed the information for [Reference Number: XXXXXXXX]. Based on our review, our decision is that you [**select one:** have **OR** have **not**] provided enough evidence to demonstrate that the difference between the billed charges and the Good Faith Estimate is medically justified and based on unforeseen circumstances that could not have been reasonably anticipated.

[If have prevailed:]
Based on this decision, [patient name] must pay [**select one**: $XXX, which is the total expected charges provided in the Good Faith Estimate minus the $25 administration fee the patient paid for the dispute process **OR** $YYY, which is the billed charge **OR** $ZZZ, which is the median amount for the same or similar services by a same or similar provider in your geographic area]. You must arrange for such payment directly with [patient name].

[If have not prevailed:]
Based on this decision, [patient name] must pay [**select one**: $XXX, which is the total expected charges provided in the Good Faith Estimate minus $25 that you must credit to the patient for the administration fee they paid for the dispute process **OR** $YYY, which is the billed charge minus $25 that you must credit to the patient for the administration fee they paid for the dispute process **OR** $ZZZ,

which is the median amount for the same or similar services by a same or similar provider in your geographic area minus $25 that you must credit to the patient for the administration fee they paid for the dispute process]. You must arrange for such payment directly with [patient name].

This decision is binding, unless there are claims of fraud or a misrepresentation of facts presented to us, in which case you may have the right to other legal remedies. For more information, see www.cms.gov/nosurprises.

Sincerely,

[SDR entity name and contact information]