OMB Control Number: 1210-0169
Expiration Date: 04/30/2022

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 and its implementing regulations, the U.S. Department of Health & Human Services (HHS) is required to establish a patient-provider dispute resolution process where a Selected Dispute Resolution (SDR) entity can resolve a payment dispute between individuals who are not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan (uninsured individuals), or who are not seeking to file a claim with their group health plan, health insurance or coverage, or FEHB health benefits plan (self-pay individuals), and health care provider, or facility, or provider of air ambulance services by determining the amount such individual is must to pay to such their health care provider, or facility, or provider of air ambulance services. Under federal criteria, HHS SDR entities will review initiation notices to determine that an uninsured (or self-pay) individual is eligible to dispute a bill.

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

<u>NOTE</u>: 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, orformal 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 1210-0169. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time toreview 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.

Selected Dispute Resolution (SDR) Entity Decision Notice to Uninsured (or self-pay) Individual

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] [<u>select one</u>: has <u>OR</u> has **not**] provided enough credible information to demonstrate the difference between the amount billed and the Good Faith Estimate reflects the costs of a medically necessary item or service and is based on unforeseen circumstances that could not have been reasonably anticipated when the good faith estimate was provided.

Based on this decision, **[uninsured (or self-pay) individual name] must pay [<u>select one</u>:** $XXX, which is the total expected charges **[for AA item/service] [and BB item/service if needed and CC item/service if needed etc.]** from the Good Faith Estimate**,** minus the $25 administration fee that you paid **<u>OR</u>** $YYY, which is the billed charge **[for AA item/service] [and BB item/service if needed and CC item/service if needed etc.] <u>OR</u>** $ZZZ,which is the median amount paid by a group health plan or health insurance issuer for the same or similar **[AA services] [and BB item/service if needed and CC item/service if needed etc.]** by a same or similar provider in your geographic area**]**. [Uninsured (or self-pay) individual name] must directly pay [health care provider or facility 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. Also, [health care provider or facility name] may provide financial

assistance or agree to an offer for a lower payment amount, or [Uninsured (or self-pay) individual name] may agree to pay the billed charges in full, or may agree with [health care provider or facility name] on a different payment amount.

For more information, visit www.cms.gov/nosurprises/consumers.

Sincerely,

[SDR Entity Name], Selected Dispute Resolution Entity

[Company email]

[Company phone]

[Company Fax #]

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 determination is that you **[select one: have OR have not]** provided credible information to demonstrate that the difference between the billed charges and the Good Faith Estimate reflects the costs of a medically necessary item or service and based on unforeseen circumstances that could not have been reasonably anticipated.

[If uninsured (or self-pay) individual prevailed:]
Based on this decision, [patient name] must pay $XXX, which is the total expected charges **[select one: [for AA service] [and BB item/service if needed and CC item/service if needed etc.]** provided in the Good Faith Estimate minus the $25 administration fee the uninsured (or self-pay) individual paid for the dispute process **OR** $ZZZ, which is the median amount for the same or similar **[AA services] [and BB item/service if needed and CC item/service if needed etc.]** by a same or similar provider in your geographic area**]**. You must arrange for such payment directly with [uninsured (or self-pay) individual name].

[If health care provider or facility prevailed:]
Based on this decision, [patient name] must pay $YYY, which is the billed charge **[for AA service] [and BB item/service if needed and CC item/service if needed etc.]**. You must arrange for such payment directly with [uninsured (or self-pay) individual 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. Also, [health care provider or facility name] may provide financial assistance or agree to an offer for a lower payment amount, or [Uninsured (or self-pay) individual name] may agree to pay the billed charges in full, or may agree with [health care provider or facility name] on a different payment.

For more information, visit www.cms.gov/nosurprises/consumers.

Sincerely,

[SDR Entity Name], Selected Dispute Resolution Entity

[Company email]

[Company phone]

[Company Fax #]

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.