

APPENDIX 7

**Patient-Provider Dispute Resolution Process
 Data Elements**

The Departments of the Treasury, Labor and Health and Human Services (the Departments) have issued the Requirements Related to Surprise Billing; Part II interim final rule ([86 FR 55980](#)), which provides protections for the uninsured. This rule requires the Secretary of HHS to establish a process referred to as the patient-provider dispute resolution process. Under this process, an uninsured (or self-pay) individual may seek a determination from a Selected Dispute Resolution (SDR) entity for any billed charges from a provider¹ or facility that are substantially in excess of the good faith estimate provided by that health care provider or facility in advance of receiving the items or services. These requirements provide for an SDR entity to review and make an independent, binding determination of the payment amount for items and services. The SDR entity must be certified by the Secretary under 45 CFR 149.620(d). HHS intends to contract with between 1 and 3 SDR entities that meet the certification requirements outlined in 45 CFR 149.620(d), rather than pursue an open certification process as is the case for certified Independent Dispute Resolution (IDR) entities in the federal IDR process.

The table below identifies for purposes of the PRA data elements that an uninsured (or self-pay) individual, provider, or facility is required to include in the patient-provider dispute resolution process under 45 CFR 149.620.

| RESPONSIBLE PARTY | DATA ELEMENT | DESCRIPTION |
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| Provider or Facility | Copy of the Good Faith Estimate | A copy of the notification of expected charges for a scheduled or requested item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a co-health care provider or co-health care facility consistent with statutory provisions in PHS Act section 2799B-6(2) and 45 CFR 149.620. |
| Provider or Facility | Copy of the Billed Charges | A copy of the billed charges provided to the uninsured (or self-pay) individual for the item or service under dispute. |
| Provider or Facility | Justification for the Difference Between the Good Faith Estimate and the Bill | If available, documentation to demonstrate that the difference between the billed charges and the expected charges reflects the costs of a medically necessary qualified item or |

¹ For ease of reference, for purposes of this document, the term “provider” should be considered to include providers of air ambulance services.

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| | | service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider or facility when the good faith estimate was provided. |
| Provider or Facility | Contact Information of the Health Care Provider or Health Care Facility (if not included in Good Faith Estimate) | Contact information of the health care provider or health care facility involved, including name, email address, phone number, and mailing address, in the event that it is not included in the good faith estimate. |
| Uninsured (or Self-Pay) Individual | Information on the Item or Service Under Dispute | Information sufficient to identify the item or service under dispute, including the date of service or the date the item was provided. |
| Uninsured (or Self-Pay) Individual | Copy of the Provider's or Facility's Total Billed Charges for the Items or Services | A copy of documentation showing the total billed charges, by each health care provider or health care facility, for all primary items or services that were provided to an uninsured (or self-pay) individual and all other items and services furnished in conjunction with the primary items and services, regardless of whether such items or services were included in the good faith estimate. |
| Uninsured (or Self-Pay) Individual | Last 4 digits of Account Number on bill with disputed cost item or service | Information sufficient for the provider or facility to identify the correct patient and provide the SDR entity with the requested information to conduct the PPDR process. |
| Uninsured (or Self-Pay) Individual | Copy of the Good Faith Estimate | A copy of the notification of expected charges for a scheduled or requested item or service, including and items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service, provided by a co-health care provider or co-health care facility consistent with statutory provisions in PHS Act section 2799B-6(2) and 45 CFR 149.620. |
| Uninsured (or Self-Pay) Individual | Contact Information of the Parties Involved | Contact information for the uninsured (or self-pay) individual and of the providers and facilities involved, including name, email address, phone number, and mailing address in the event that it is not included in the good faith estimate. |
| Uninsured (or Self-Pay) Individual | State Where the Item or Service in Dispute Was Furnished | The State where the item or service in dispute was furnished, in the event that it is not included in the good faith estimate. |
| Uninsured (or Self-Pay) Individual | Communication Preference | The uninsured (or self-pay) individuals communication preference, through the |

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| | | federal IDR portal, or electronic or paper mail. |
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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 of 13.5 hours per respondent, 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.

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.