OMB Control Number: 0938-NEW
Expiration Date: XX/XXXX

APPENDIX 3

Standard Notice: Ineligible for Patient-Provider Dispute Resolution or Additional Information Needed

(For use by Selected Dispute Resolution Entities to Send to Uninsured (or Self-Pay) Individuals or their Authorized Representatives 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 coverage, or FEHB health benefits plan (self-pay individuals), and health care provider, facility, or provider of air ambulance services by determining the amount such individual must pay to their health care provider, facility, or provider of air ambulance services. Under federal criteria, SDR entities will review initiation notices to determine that an uninsured (or self-pay) individual is eligible to dispute a bill.

This notice will be used by SDR entities to inform an uninsured (or self-pay) individual or their authorized representative that the uninsured (or self-pay) individual is not eligible for dispute resolution or that their submission to initiate dispute resolution was incomplete. If the submission is incomplete, the notice informs the uninsured (or self-pay) individual or their authorized representative of what is required to establish eligibility for dispute resolution.

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 1210-0169. 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.

[SDRE logo] [SDRE address]

Date

[Uninsured/Self-pay Individual or Authorized Representative Name]
[Uninsured/Self-pay Individual or Authorized Representative Address]
[Uninsured/Self-pay Individual or Authorized Representative City, State, Zip]

RE: Information about your Patient-Provider Dispute Resolution Case, Reference Number: XXXXXXXX

[Uninsured (or self-pay) Individual or Authorized Representative Name],

We have received your form to start the patient-provider dispute resolution process, Reference Number [insert number], received on [insert date].

[*If rejection based on eligibility*] Based on our review, you are not eligible for the patient-provider dispute process because [*select all that apply from the following*]

- ☐ The bill from any provider or facility is not at least $400 more than the Good Faith Estimate (GFE) from that provider or facility.
- ☐ [HHS received your form / your form was postmarked] on [insert date], which was 120 calendar days (or more) after the date on the bill.

While you can't use the patient-provider dispute resolution process for this bill, you can still contact the health care provider or facility listed on the Good Faith Estimate to negotiate the bill and ask for financial assistance. [*END*]

[*If rejection based on deficiencies*] Based on our review, we need more information to process your dispute. Please send the following:

[*List only deficiencies discovered*]:

The name of the services and/or items you want to dispute

- ☐ The date you received the services and/or items
- ☐ A short description of the services and/or items
- ☐ A copy of the bill for the services and/or items you want to dispute
- ☐ A copy of the Good Faith Estimate

- ☐ Contact information for the health care provider or facility, including name, email address, phone number and mailing address
- ☐ Payment of Administrative Fee

Please send these **supporting documents or payment by {insert date that is 21 calendar days from the date on this letter}** using one of the following options:

Online:
www.cms.gov/nosurprises/consumers

Mail: [SDR Entity Address]

Online payments: [insert payment information here]

Mail payment: Cashier's check or money order payable to [SDR Entity]
Mail to: [SDR Entity Address]

Please include your reference number [reference number] on all documents you send.

Once we receive your information, we will continue the patient-provider dispute resolution process. If you do not respond within 21 calendar days of the date on this letter, we may reject your request to use the patient-provider dispute process. [*END*]

Sincerely,

[SDR Entity]
[Address line 1]
[Address line 2]

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.