Privacy Policy

Last updated: MONTH XX, 2021

The Centers for Medicaid and Medicare Services (CMS) ("us", "we", or "our") operates http://www.cms.gov/nosurprises (the "Site"). This page informs you of our policies regarding the collection, use and disclosure of Personal Information we receive from users of this form.

By using the No Surprises Complaint form (form), you agree to the collection and use of information in accordance with this policy.

Information Collection And Use

While using our form, we may ask you to provide us with certain personally identifiable information that can be used to contact or identify you. Personally identifiable information (PII), defined by the Office of Management and Budget (OMB), refers to information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

When you fill out this form:

After you submit a complaint, your personal information may be disclosed to other federal agencies as they may have jurisdiction authority to review and investigate your complaint, if applicable. These organizations may include the U.S. Office of Personnel Management (OPM), the Treasury Department (Treasury), and the U.S. Department of Labor (DOL).

In accordance with the Privacy Act of 1974, a system of records has been created for the collection of personally identifiable information you submit on this form. The original system of records notice entitled, "No Surprises Complaint Form" was published in the Federal Register on MONTH XX, 2021.

The system of records and modifications can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/CMS-Systems-of-Records.html.

For specific details on the data collected by the systems that make up the form, please view the Privacy Impact Assessments (PIA) located at: http://www.hhs.gov/pia/.

Log Data

Like many site operators, we collect information that your browser sends whenever you visit our Site ("Log Data").

This Log Data may include information such as your computer's Internet Protocol ("IP") address, browser type, browser version, the pages of our Site that you visit, the time and date of your visit, the time spent on those pages and other statistics.

CMS will keep data collected long enough to achieve the specified objective for which they were collected. Once the specified objective is achieved, the data will be retired or destroyed in accordance with published draft records schedules of CMS as approved by the National Archives and Records Administration.

CMS does not store information from cookies on CMS systems. CMS assesses whether the expiration date of a cookie exceeds one year and provides an explanation as to why cookies with a longer life are used on the site in the associated Third-Party Website or Application Privacy Impact Assessment. These explanations can be found at http://www.hhs.gov/pia#Third-Party.

Communications

We may use your Personal Information to contact you if we need more information or documentation, or to notify you of the resolution to your complaint. We may contact you by phone and/or email, dependent on the contact information that you provided to us.

Cookies

Cookies are files with small amount of data, which may include an anonymous unique identifier. Cookies are sent to your browser from a web site and stored on your computer's hard drive.

Like many sites, we use "cookies" to collect information. You can instruct your browser to refuse all cookies or to indicate when a cookie is being sent. However, if you do not accept cookies, you may not be able to use some portions of our Site.

Security

The security of your Personal Information is important to us, but remember that no method of transmission over the Internet, or method of electronic storage, is 100% secure. While we strive to use commercially acceptable means to protect your Personal Information, we cannot guarantee its absolute security.

Changes To This Privacy Policy

This Privacy Policy is effective as of MONTH XX, 2021 and will remain in effect except with respect to any changes in its provisions in the future, which will be in effect immediately after being posted on this page.

We reserve the right to update or change our Privacy Policy at any time and you should check this Privacy Policy periodically. Your continued use of the Service after we post any modifications to the Privacy Policy on this page will constitute your acknowledgment of the modifications and your consent to abide and be bound by the modified Privacy Policy.

If we make any material changes to this Privacy Policy, we will notify you either through the email address you have provided us, or by placing a prominent notice on our website.

Contact Us

If you have any questions about this Privacy Policy, please contact us.

No Surprises Provider Complaint form

**** Indicates a required field***

Document Submission
Are you submitting documentation for a previous complaint? Yes ☐ No ☐
Please provide your ticket number _____ I don't have it. ☐
Complaint Category
Independent Dispute Resolution (IDR):
☐ **IDR Fee Collection**: I have a question related to IDR Fee Collection.
☐ **IDR Certification Inquiry, Case Initiation/Management:** I have a question about how to start the IDR process or how to initiate or manage my case, or I have a question on how to certify as an Independent Dispute Resolution Entity (IDRE).
☐ **IDR Complaint:** I am a provider, and I have a complaint about an issuer or plan who I believe is not complying with the dispute resolution process.
☐ **I have an inquiry not listed here about IDR.**
☐ **I have a complaint related to the No Surprises Act that is not listed above.**

Patient Information
Name:
Address:
City:
State:
Zip:
Telephone Number
Email:
Policyholder information (if different than patient)
Name of policyholder:
Address:
City:
State:
Zip:
Telephone Number:
Email:
Medical Provider Information

Are you reporting a violation on behalf of someone else? Yes ☐ No ☐
Name:
Telephone Number:
Email:
Medical provider, Air-Ambulance Provider, and/or Health care facility Information
Click all that apply: Provider ☐ Air-Ambulance Provider ☐ Health Care Facility ☐
Name:
Address:
City:
State:
Zip:
Telephone Number:
Email:
Employer Identification Number (EIN):
National Provider Identifier (NPI)
☐ In-Network ☐ Out-of-Network
Do you prefer to be contacted by: Telephone ☐ Email ☐
Insurance Company/Plan Information
Name of Health Insurance Plan or Company: _____
Policy or ID #
Group Number: _____ N/A ☐
Claim Numbers: _____
CPT Codes: _____
What type of coverage or plan is this?
☐ Non-Federal Governmental Plan
☐ Self-funded group health plan from a private employer
☐ Fully-insured group health plan from private-sector employer
☐ Federal Employees Health Benefits (FEHB) Plan
☐ Individual Health Insurance Plan outside the Health Insurance Marketplace
☐ Health Insurance Marketplace Plan
Marketplace Application ID _____
☐ State-Based Marketplace
☐ Medicaid or the Children's Health Insurance Program (CHIP)
☐ Faith-Based Plan
☐ TRICARE
☐ Other: _____

Explain the specific problem you are having
[Free Text]
State where service was received (if different from provider's current address)
State _____
Date(s) of Service Related to the Complaint
[Free Text]
Action(s) Previously Taken to Resolve
[Free Text]

Documentation
Please submit applicable supporting documentation below. Failure to provide supporting documentation may prevent us from investigating your complaint.
☐ Notice of Consent (Signed and Dated)
☐ Advanced Cost Information (also known as a "Good Faith Estimate")
☐ Bill(s) from plan, issuer, provider, air ambulance provider, or health care facility
☐ Correspondence
☐ Explanation of Benefits received from your health plan or insurer (for date of service)
☐ Notices of Appeal decision(s)
☐ Front and back of health insurance card
☐ Claim(s)
☐ Evidence of Coverage (Examples - Summary plan description, Policy, Certificate, Contract of

insurance, Membership booklet, or Outline of coverage)
☐ Other

Declaration
By filling in my name and date below, I declare the information contained on this form is true and accurate.
Name:
Signature:
Date: MM/DD/YYYY

Submit
Once you've completed this form and attached supporting documentation, please click on the Submit button below: ☐ **SUBMIT** **Questions?** Call the No Surprises Help Desk at: 1-800-985-3059 https://www.cms.gov/nosurprises