OMB control number: 0939-1406
Expiration date: XX/XX/XXXX

No Surprises Provider Complaint form

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0939-1406.** The expiration date is **XX/XX/XXXX.** This is required to retain a benefit. The time required to complete this information collection is estimated to **average 30 minutes 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.

** Indicates a required field*

Document Submission
Are you submitting documentation or information for a previous complaint? Yes ☐ No ☐
If yes, please provide your ticket number _____; Or check here if you don't have your ticket number. ☐
Additional Information: [Text Field]
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: Mobile ☐ Home ☐ Work ☐
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™
☐ Federal Health Insurance Marketplace™ Plan
Marketplace Application ID _____
☐ State-based Marketplace
Marketplace Application ID _____
☐ 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