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

APPENDIX 2

Patient-Provider Dispute Resolution Form

Find out if you qualify for the dispute resolution process

This form is only for people who do **not** have health care coverage or who decided not to use their coverage for this health service or item.

Did your health care provider[s]/facility[ies] give you a Good Faith Estimate for a health care item or service?	Yes ☐	No ☐
Is the bill from your health care provider[s]/facility[ies] at least $400 more than the Good Faith Estimate from that [those] provider[s]/facility[ies]?	Yes ☐	No ☐
Is the **date on the top of the bill with the item or service you want to dispute** within the last 120 calendar days (about 4 months)?	Yes ☐	No ☐

If you answered **NO** to any of these questions:

- You do not qualify for the dispute resolution process. You can contact your health care provider to negotiate your bill and ask for financial assistance.
- If you think you should have been given a Good Faith Estimate or have other questions, please visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

If you answered **YES** to **ALL** of these questions:
You may qualify for the dispute resolution process. Please complete the rest of this form.

Note: While you are disputing your bill, your provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any action against you for disputing your bill. During the dispute resolution process, you can still ask your health care provider for a lower bill.

Patient name (and Authorized Representative name, if needed)

First Name Middle Name Last Name

(Optional) **If you are filling out this form for the patient, please print your name here:**

☐ Check this box if you are an Authorized Representative and should be contacted instead of the patient. Write **your** information in the "mailing address and phone number" section.

Note: This is common for patients under age 18 or patients who need help completing medical forms.

Patient's (or Authorized Representative's) Contact Information

Street or PO Box Apartment

City State ZIP

Phone Email Address

Contact Preference: [ ] By mail [ ] By email [ ] By phone

Details about the health care item or service you want to dispute

The State where the patient received the item or service:

The date when the item or service was scheduled (or when the cost estimate was requested):

Month: Day: Year:

The date when the patient received the item or service:

Month: Day:

Year:

Write a short description of the item or service you want to dispute.
(Include: Name of the service/item to dispute and a short description of the service/item.)

I have included with this form:

☐ A copy of the bill[s] from my health care provider[s]/facility[ies] that I want to dispute

☐ A copy of the Good Faith Estimate for the item or service that I want to dispute

Contact information for the health care provider/facility that provided the item or performed the service in dispute. This should be on your Good Faith Estimate.

Health Care Provider / Facility Name

Last 4 digits of the Account Number on your bill

Street

City | State | ZIP

Email | Phone

Read and sign

- I agree to let my health care provider release all relevant medical or treatment records related to this dispute to a Selected Dispute Resolution (SDR) entity as selected by the U.S. Department of Health and Human Services (HHS). I understand the SDR entity will only use this information to make a decision on this dispute. My information will be kept confidential and not released to anyone else.
- I agree to pay a $25 fee for the dispute process. Payment is required to start the dispute process. I Personal checks or cash will not be accepted. Accepted forms of payment are: cashier's check, money order, or electronic payment such as credit or debit card payment, or payment app. Payments should be made payable to [SDR Entity].
- When the SDR entity makes the decision about the price for these health care items or services, I agree to pay the decided amount.

☐ Check here to agree

Signature Date

Print Name

How to send this form

Make sure you have included:

- A copy of the **bill** from your health care provider or facility that you want to dispute
- A copy of the **Good Faith Estimate** for the item or service that you want to dispute
- Your $25 Administrative Fee (If using mail)

You can send this form and documents:

- **Online**
  www.cms.gov/nosurprises/consumers

- **By mail**
  [SDR entity name]
  Address
  Address

For additional help call 1-800-985-3059 or e-mail FederalPPDRQuestions@cms.hhs.gov

If you prefer to pay electronically, when the SDR entity receives this form, they will send you a link where you can electronically pay the fee to start the dispute process. If you are mailing your fee, send a cashier's check or money order payable to [the SDR Entity] with your form. Do not send cash or personal checks as they are not acceptable forms of paying your administrative fee.

Keep a copy or take pictures of this completed form. You may need it later.

For more information about your right under federal law to dispute medical bills, visit:
www.cms.gov/nosurprises/consumers

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.

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.