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

APPENDIX 8

Standard Notice: Uninsured (or Self-Pay) Individual and Provider or Facility Settle on a Payment Amount After Initiating Patient-Provider Dispute Resolution

(For use by health care providers and facilities 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 is for use by the health care provider or facility to notify the SDR entity in the event that both parties agree to settle on a payment amount after the patient-provider dispute resolution process has been initiated and **prior to the SDR entity making a determination**. While the determination by the SDR entity is pending, the two (2) parties to the patient-provider dispute resolution process (the uninsured (or self-pay) individual and their authorized representative and the health care provider or health care facility) may agree to resolve the dispute by settling on a payment amount. When the parties settle on the amount, federal standards require the provider or facility to notify the SDR entity no later than three (3) business days after the date of the agreement.

HHS has developed this model notice so that providers or facilities may use it to inform SDR entities that a settlement has been reached between an uninsured (or self-pay) individual and the health care provider or facility. To use this model notice, the provider or facility must fill in the blanks with the appropriate information.

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, including the HHS interim final rules (IFR) *Requirements Related to Surprise Billing; Part II*, published on October 7, 2022.

Providers and facilities should not include these instructions with the documents they give to the selected SDR entities.

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.

Health Care Provider or Facility Notice of Payment Settlement to Selected Dispute Resolution Entity

A health care provider or facility must complete this form when they, in partnership with the uninsured (or self-pay) individual or the individual's authorized representative have resolved a payment dispute outside of the dispute resolution process.

Federal standards require health care providers and facilities notify the Selected Dispute Resolution (SDR) entity, no later than 3 business days after the date of the settlement.

Please complete the information about the payment agreement.
Today's date:_____/_____/_____
SDR Entity Name:
Reference Number:
Provider or Facility Name:
Agreed Payment Amount
Date when the new payment agreement was reached: _____/_____/_____
Select one: ☐ We agreed to a new payment amount. The final payment amount for the uninsured (or self-pay) individual is: $ ☐ We agreed to provide financial assistance. The final payment amount for theuninsured (or self-pay) individual is: $

Uninsured (or Self-pay) Individual Information		
Uninsured (or self-pay) Individual Name: First Name	Middle Name	Last Name
(optional) Authorized Representative Name:		
Health Care Provider or Facility Information		
Health Care Provider or Facility Name		
Street		
City	State	ZIP
Email	Phone	
I have included with this form (check one)**:**		
☐ Documentation from and/or signed by the uninsured (or self-pay) individual agreeing to the new payment amount.		
☐ I acknowledge that the final payment amount agreed upon includes a refund for at least half the cost of the $25 administrative fee ($12.50) paid by the uninsured (or self-pay) individual or authorized representative for the dispute resolution request.		

Once you submit this form, the SDR entity will confirm receipt of documentation and notify the uninsured (or self-pay) individual of the reduced Administrative fee. If you have any questions email FederalPPDRQuestions@cms.hhs.gov.

For more information visit www.cms.gov/nosurprises/consumers.

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