OMB Control Number XXXX-XXXX
Expiration Date MM/DD/YYYY

APPENDIX 3

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

(For use by the Secretary of the Department of Health and Human Services (HHS) to Uninsured Individuals or their Authorized Representatives beginning January 1, 2022)

Instructions

Under Section 2799B-7 of the Public Health Service Act, 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 plan or coverage or a Federal health care program, or who are not seeking to file a claim with their plan or coverage, and health care provider or facility by determining the amount such individual is to pay to such health care provider or facility. Under federal criteria, HHS 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 HHS to inform an uninsured (or self-pay) individual or their authorized representative that they are 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 become eligible 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 0938-XXXX. The time required to complete this information collection is estimated to average xx 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.

OMB Control Number XXXX-XXXX
Expiration Date MM/DD/YYYY

HHS Logo

U.S. Department of Health & Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201

Date

Uninsured Individual or Authorized Representative Name
Uninsured Individual or Authorized Representative Address
Uninsured 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 is not at least $400 more than the Good Faith Estimate (GFE).
- ☐ We received your form 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

Please send these **supporting documents within 15 business days of the date on this letter** using one of the following options:

Online: www.cms.gov/nosurprises

Email: address@XXX.gov

Mail: [SDR Entity]
Address
Address

Please include your reference number [reference number] on all documents you send. If you're sending documents in an email, please include the reference number in the subject line.

Once we receive your information, we will continue the patient-provider dispute resolution process. If you do not respond within 15 business days of the date on this letter, we may reject your request to use the patient-provider dispute process.[*END*]

Sincerely,

[Patient-Provider Dispute Resolution]
[SDR Entity]
[Address line 1]
[Address line 2]