You can submit a complaint with us

When your provider or insurer might not be following the rules

Health insurance companies and health care providers and facilities must follow rules that protect you from unexpected, or "surprise," out-of-network bills.

If you have a question about these rules or believe the rules aren't being followed, you can submit your question or complaint to the No Surprises Help Desk.

On this page

- What to expect
- What you need
- What happens next
- Submit a complaint

Submit a complaint

If your insurance company or provider isn't following surprise billing rules, submit a complaint.

Get Started

Update an existing complaint →

Submit a complaint over the phone:
1-800-985-3059

What to expect

Your complaint will go to the No Surprises Help Desk. The Help Desk can:

- Review your complaint to make sure your health insurance company, health care provider, or health care facility followed surprise billing rules.
- Investigate compliance with federal laws and policies under our jurisdiction.
- Refer your complaint to another applicable federal or state enforcement authority, if necessary.

Call the Help Desk at 1-800-985-3059 to get help submitting your complaint or to find out your next steps. We can help you in English, Spanish and over 350 other languages.

What you need

Before you submit your complaint, gather any supporting documentation you have. The more information we have, the faster we'll be able to process your complaint.

You don't need to provide every document on this list. Include the documents that you have easy access to. If we need something else, we'll let you know. Call us at 1-800-985-3029 if you have any questions.

You can return to your submission and add additional documents later, if needed.

Make a digital copy or take a photo of any of the following documents that apply to your situation:

Provide these documents if possible:

- Your medical bill
- A photo of your health insurance card, if you used insurance
- An explanation of benefits (if you got one)

You might also include, if available and relevant:

- Your good faith estimate (if you got one)
- A notice and consent form, signed and dated (if you got one)
- Any correspondence you had with your provider
- A notice of appeal decision(s)
- Any evidence of coverage (like a summary plan or membership booklet)

You'll be prompted to upload your documents when you fill out the complaint form online.

Note: We reset this form after 15 minutes of inactivity to protect your data. Your answers will be deleted if the form closes.

What happens next

Write down your confirmation number.

If you provided your email address, you'll get an email from **noreply_nosurpriseshelpdesk@cms.hhs.gov.** Keep this email for your records.

We'll review your complaint or question and any documents you submitted. If we need more information, we'll get in touch within 60 days using your preferred contact method.

Call the No Surprises Help Desk at 1-800-985-3059 to check on the status of your complaint or if you have any questions. Be sure to reference your confirmation number.

You can return to your submission to add additional documents. To do this, go to your existing complaint and enter your confirmation number.

Submit a complaint

Before you get started

Read and agree to the Security and Privacy Agreement.

¿Sabe que esta forma también está disponible español?

Cambiar a Español

Here's a quick summary of the security and privacy agreement:

- We're collecting this information in a secure, government-hosted environment. We use Salesforce, a software application.
- We are authorized to collect information in this way by the No Surprises Act.
- It is completely voluntary for you to submit a complaint.
- To process your complaint, we may share the information provided with others. This could include your state officials, your insurance company, and your provider.
- If this privacy notice changes, we will post an update to this website.

Please read through each section below before accepting.

- Privacy Notice and Terms of Use +
- CMS/HHS Vulnerability Disclosure Policy +
- CMS.gov Privacy Policy +
- No Surprises Help Desk Privacy Act Statement – effective January 1, 2022 +
- Changes to this Privacy Notice and Terms of Use +
- OMB control number and time to complete form +

Accept

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Did you use insurance when you got care?

You can submit this form on someone else's behalf. Answer these questions as if you were that person. We'll ask for your contact information at the end of the form.

* **Choose one of the following options.**

- ◯ Yes, I used insurance when I got care
- ◯ No, I did not use insurance

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

What issue do you need help with?

* **Choose one of the following options.**

Pick the option that fits your situation best. Or pick "it's something else."

- I received emergency care at a hospital and received a bill from an out-of-network provider.
- I received care at an in-network facility but received a bill from an out-of-network provider.
- I received care within 90 days of my provider leaving my health plan's network, but I was charged at out-of-network rates.
- My provider didn't tell me about my medical billing protections.
- My insurance company is not complying with the Mental Health Parity and Addiction Equity Act (MHPAEA).
- It's something else.

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com Sign up

Submit a complaint

What issue do you need help with?

* **Choose one of the following options.**

Pick the option that fits your situation best. Or pick "it's something else."

- ○ My provider didn't give me a good faith estimate. Or they billed me more than the amount in the estimate.
- ○ My provider isn't complying with the dispute process. Or they're still billing me for a larger amount after a dispute was decided in my favor.
- ○ It's something else.

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com Sign up

Submit a complaint

Tell us about yourself.

Your Name

* First name

* Last name

Your Mailing Address

* Street address 1

Street address 2

* City

* State or territory

-Select a state-

* Zip code

Your Contact Methods

How do you prefer to be contacted

* Phone number

Enter a 10 digit phone number with no dashes or parentheses to continue. Example: 2223334444

Email address

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Tell us more about yourself.

Gender, age, race, and ethnicity

Providing demographic information is optional. We use this data to improve equity in quality of care.

Giving us this information won't impact how we resolve your complaint.

Answer if you feel comfortable doing so.

All information you share, including demographic information, is confidential and protected.

Gender

- ○ Female
- ○ Male
- ○ Non-binary
- ○ Other
- ☐ Prefer not to say

Age

☐ Prefer not to say

Race

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Prefer not to say

Ethnicity

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ☐ Prefer not to say

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com Sign up

Submit a complaint

When and where did you receive medical care?

* **Date of care (MM/DD/YYYY)**

You may have more than one date of care for this incident. Enter the most recent date related to this complaint.

* **State or territory**

-Select a state-

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Just a reminder...

This is an official form of the United States government.

We're about to ask you for more details about your provider and insurance. We use this information to review your complaint.

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com Sign up

Submit a complaint

Who is this complaint against?

Let us know who this complaint is about. Examples include your doctor, hospital, or insurance company.

Who should I put here?

* Pick the type of provider this complaint is against.

- Health Care Provider
- Health Care Facility
- Insurance Company or Plan
- Air-Ambulance Provider
- Other

* Provider name

Is this provider in-network or out-of-network?

- Select an option -

Provider phone number

Enter a 10 digit phone number with no dashes or parentheses to continue. Example: 2223334444

Provider email address

Provider physical address

This is the physical location where you received care.

If you're not sure what address to enter, enter the one that applies best to your situation.

* Street address 1

Street address 2

* City

* State or territory

- Select a state -

* Zip code

Additional provider details

You may have your provider's Employer Identification Number (EIN) or National Provider Identifier (NPI) number. If you're not sure, leave these fields empty.

Provider EIN

Provider NPI

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Share what happened

To process your complaint, we want to know more about what happened.

* **Tell us about your issue.**
You can enter up to 1024 more characters.

Documentation

Provide any documentation that might support your case. You can supply documentation later, if you don't have it handy right now.

Uploading these documents is optional. But they help us understand your issue and review your complaint as fast as possible.

Accepted file types: Word (DOC, DOCX), Excel (XLS, XLSX), PDF, JPG, PNG

Bill(s)
Upload any bills you received from your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files
Maximum file size: 185 MB

CPT codes
If you see CPT codes on your bill, enter them here.
Otherwise, leave this field blank.

Claim(s)
Upload any claims you received from your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files
Maximum file size: 185 MB

Claim number
If you were given a claim number, enter it here.
Otherwise, leave this field blank.

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email
you@example.com
Sign up

Submit a complaint

What have you done so far to try to resolve this issue?

* **What steps have you taken?**
You can enter up to 500 more characters.

Documentation

Provide any documentation of correspondence. You can supply documentation later, if you don't have it right now.

Uploading documentation is optional. But it helps us understand your issue and review your complaint as fast as possible.

Accepted file types: Word (DOC, DOCX), Excel (XLS, XLSX), PDF, JPG, PNG

Correspondence
Upload documentation of any correspondence you had with your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files

Maximum file size: 185 MB

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Tell us about your insurance.

These questions are optional, but answer them if you can.

This information will help us understand exactly what laws apply to you.

Plan Type

* **What type of insurance or health plan did you use when you got care?**

- (●) **Non-Federal government plan**
  You work for a state or local government or a school district and use their health plan.
- ( ) **Self-funded group health plan from a private employer**
- ( ) **Federal Employees Health Benefits (FEHB) Plan**
- ( ) **Fully-insured group health plan from private-sector employer**
- ( ) **Individual health insurance plan outside the Health Insurance Marketplace™**
- ( ) **Federal Health Insurance Marketplace™ plan**
- ( ) **State-based Marketplace plan**
- ( ) **Medicaid or the Children's Health Insurance Program (CHIP)**
- ( ) **Faith-Based Plan**
- ( ) **TRICARE**
- ( ) **I'm not sure / Other**

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Tell us more about your insurance.

Upload a picture of your insurance card.

Upload a picture of your insurance card. This helps us understand your issue and review your complaint as fast as possible.

You can upload the pictures later if you don't have your card right now.

Accepted file types: Word (DOC, DOCX), Excel (XLS, XLSX), PDF, JPG, PNG.

* **Insurance card (front)**

Upload one or more files

Maximum file size: 185 MB

* **Insurance card (back)**

Upload one or more files

Maximum file size: 185 MB

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com

Sign up

Submit a complaint

Tell us more about your insurance.

Next, enter more details about your insurance.

Tell us more about your insurance plan, even if some of this information is on your insurance card. This helps us resolve your complaint faster.

Your plan

Plan name

Policy number

Group number

Plan sponsor

Employer or union name

Employer or union phone number
Enter a 10 digit phone number with no dashes or parentheses to continue. Example: 2223334444

Policyholder details

☑ I am the policyholder

Policyholder mailing address

☑ This is the same as my mailing address

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Review and add documents related to your complaint.

Uploading these documents helps us understand your issue and review your complaint as fast as possible.

You can return to this page later on to add additional documentation.

Accepted file types: Word (DOC, DOCX), Excel (XLS, XLSX), PDF, JPG, PNG

* **Insurance card (front)**

Upload one or more files

Maximum file size: 185 MB

* **Insurance card (back)**

Upload one or more files

Maximum file size: 185 MB

Bill(s)

Upload any bills you received from your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files

Maximum file size: 185 MB

Explanation of benefits

Upload the explanation of benefits you received from your health plan or insurer that covers your date(s) of service.

Upload one or more files

Maximum file size: 185 MB

Claim(s)

Upload any claims you received from your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files

Maximum file size: 185 MB

Correspondence

Upload documentation of any correspondence you had with your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files

Maximum file size: 185 MB

Notice and consent form

You may have signed a notice and consent form. If so, upload it here. Make sure it is signed and dated.

Upload one or more files

Maximum file size: 185 MB

Good faith estimate

Upload the good faith estimate, also known as advanced cost information, from your provider.

Upload one or more files

Maximum file size: 185 MB

Evidence of coverage

Upload your summary of plan description, policy, certificate, contract of insurance, membership booklet, or outline of coverage.

Upload one or more files

Maximum file size: 185 MB

Other

Want to share other documentation for us to review? Please share it here.

Upload one or more files

Maximum file size: 185 MB

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com

Sign up

Submit a complaint

Review and add documents related to your complaint.

Uploading these documents helps us understand your issue and review your complaint as fast as possible.

You can return to this page later on to add additional documentation.

Accepted file types: Word (DOC, DOCX), Excel (XLS, XLSX), PDF, JPG, PNG

Bill(s)
Upload any bills you received from your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files
Maximum file size: 185 MB

Correspondence
Upload documentation of any correspondence you had with your plan, issuer, air ambulance provider, or health care facility.

Upload one or more files
Maximum file size: 185 MB

Notice and consent form
You may have signed a notice and consent form. If so, upload it here. Make sure it is signed and dated.

Upload one or more files
Maximum file size: 185 MB

Good faith estimate
Upload the good faith estimate, also known as advanced cost information, from your provider.

Upload one or more files
Maximum file size: 185 MB

Evidence of coverage
Upload your summary of plan description, policy, certificate, contract of insurance, membership booklet, or outline of coverage.

Upload one or more files
Maximum file size: 185 MB

Other
Want to share other documentation for us to review? Please share it here.

Upload one or more files
Maximum file size: 185 MB

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email
you@example.com Sign up

Submit a complaint

Are you reporting on your own behalf?

* This information is required. Select an option below.

- Yes
- No, I'm reporting on behalf of someone else

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Ok, let's collect some information about you.

* Your relationship to the person you're reporting for

- Select an option -

Your name

* First name

* Last name

Your contact methods

* Phone number

Enter a 10 digit phone number with no dashes or parentheses to continue. Example: 2223334444

What type of phone number is this?

Email address

Continue

Go back

Need help completing this form?

Ver en Español

Submit a complaint

Review your responses

Did you use insurance when you got care?

Update

Yes

What issue do you need help with?

Update

I received emergency care at a hospital and received a bill from an out-of-network provider.

Tell us about yourself.

Update

First name
TestJess

Last name
TestJones

Street address 1
54 Riverside Dr.

Street address 2
No response given

City
Madison

State or territory
Wisconsin

Zip code
53703

How do you prefer to be contacted
Phone

Phone number
2121114444

Email address
No response given

Tell us more about yourself.

Update

Gender
Female

Age
40

Race
White

Ethnicity
Not Hispanic or Latino

When and where did you receive medical care?

Update

Date of care
06/01/2023

State or territory
Wisconsin

Who is this complaint against?

Update

Type of provider
Health Care Provider

Provider name
test

Provider phone number
2121113333

Provider email address
jess@coforma.io

Is this provider in-network or out-of-network?
It is in-network

Street address 1
55 Riverside Dr.

Street address 2
No response given

City
Madison

State or territory
Wisconsin

Zip code
53703

Provider EIN
No response given

Provider NPI
No response given

Share what happened

Update

I received an out-of-network bill after going to the emergency room.

Claim number
No response given

CPT codes
No response given

Bill(s)
No response given

Claim(s)
No response given

What steps have you taken?

Update

I have called my insurance company to ask for help.

Correspondence
No response given

Tell us about your insurance.

Update

Non-Federal government plan

Choose how you'd like to provide your insurance information.

Update

Upload a picture of my insurance card (preferred)

Tell us more about your insurance.

Update

Insurance card (front)

eighties_design.jpg 356.85 KB

Insurance card (back)

eighties_design.jpg 356.85 KB

Tell us more about your insurance.

Update

Plan name
No response given

Policy number
No response given

Group number
No response given

Employer or union name
No response given

Employer or union phone number
No response given

I am the policyholder
Yes

This is the same as my mailing address
Yes

Review and add documents related to your complaint.

Update

Explanation of benefits
No response given

Notice and consent form
No response given

Good faith estimate
No response given

Evidence of coverage
No response given

Other
No response given

Are you reporting on your own behalf?

Update

Yes

Continue

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com Sign up

Submit a complaint

Sign and submit your complaint

We'll investigate your complaint as soon as possible

Your signature

* **Full name**

Sign this form by checking the box

By clicking submit, you declare that the information contained on this form is true and accurate.

Submit

Go back

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com

Sign up

Submit a complaint

Don't close this window. We're submitting your complaint.

This might take a minute.

Uploading file 0 of 2

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com Sign up

Submit a complaint

Your complaint was submitted

The No Surprises Help Desk has successfully received your complaint.

Your confirmation number is 00325572.

What comes next?

Upload more documentation

You can return to this form to add supporting documentation while we review your complaint.

1. Visit the Continue a previous complaint page
2. Enter your confirmation number
3. Upload your documents
4. Sign and submit the form

We'll review your complaint

We will review your complaint or question and any documents you submitted.

We may contact you

If we need more information, we will get in touch using your preferred contact method.

We'll notify you of next steps

If you want to check on the status of your complaint, or if you are unsure what documentation you need to submit, you may contact the No Surprises Help Desk at 1-800-985-3059. Please reference your complaint ID listed above.

Go to the homepage

Need help completing this form?

Ver en Español

Get email updates

Sign up to get the latest information about your choice of CMS topics. You can decide how often to receive updates.

Email

you@example.com Sign up