

**PROVIDER AND INSURER APPLICATION
NEW YORK STATE INDEPENDENT DISPUTE RESOLUTION FOR EMERGENCY SERVICES
AND SURPRISE BILLS**

A provider or HMO/insurer (health plan) may dispute a payment or charge for emergency services or a surprise bill. Applicants must: (1) visit the Department of Financial Services (DFS) website at www.dfs.ny.gov to receive a file number; (2) complete this application; and (3) send it to the assigned independent dispute resolution entity. For help call 1-800-342-3736 or e-mail IDRquestions@dfs.ny.gov.

TO BE COMPLETED BY ALL APPLICANTS

1. File Number assigned by the DFS website: _____
 2. Applicant Name: _____
[] Provider [] Health plan (Please check one.)
 3. Patient Name: _____
 4. Patient Address: _____

 5. Patient's Health Plan ID Number: _____
 6. Health Plan: _____
 7. Health Plan Address: _____
 8. Phone Number: (_____) _____ Fax Number: (_____) _____
 9. Provider Name: _____
 10. Provider Address: _____
 11. Phone Number: (_____) _____ Fax Number: (_____) _____
 12. Email Address: _____
 13. What type of payment or charge are you disputing? (Please check one.)
[] Emergency Services [] Surprise Bill for Other than Emergency Services
 14. Date(s) of Service: _____
 15. Place of Service: _____
 16. The fee charged by the provider (and include a copy of the bill): _____
 17. The fee paid to the provider: _____
 18. The circumstances and complexity of the service including time and place, or submit when contacted by the IDRE if you want considered: _____

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19. Individual patient characteristics, or submit when contacted by the IDRE if you want considered:

20. Independent Dispute Resolution Eligibility:

- a) **For Emergency Services:** CPT codes 99281 – 99285, 99288, 99291 – 99292, 99217 – 99220, 99224 – 99226, and 99234 – 99236 are not subject to IDR if the bill does not exceed 120% of UCR and the fee disputed is \$683.22 (for 2019 and adjusted annually for inflation rates) or less.
 Yes eligible Not eligible Don't know (Please check one.)

- b) **For Surprise Bills:** Have you obtained an assignment of benefits signed by the patient and did you send it to the provider/health plan?
 Yes No (Please check one.) (If yes, please attach.)

21. Provider applicants, complete the following or submit when contacted by the IDRE:

- a) **Include a representative sample of at least 3 fees received by the provider in the last 24 months for the same service, in the same region, from health plans in which the provider does not participate.**

- b) **The provider's level of training, education and experience in relation to the service.**

- c) **The provider's usual charge for similar services when the provider does not participate with the health plan.**

22. Health plan applicants, complete the following or submit when contacted by the IDRE:

- a) **A representative sample of at least 3 fees paid by the health plan as a final payment in the last 24 months to non-participating physicians who are similarly qualified for the same service in the same region.**

- b) **The usual and customary cost for the service and the database from which this was derived.**

23. **To be completed by all applicants.**

I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree to pay the IDR fee in full within 30 days from the date of the decision if I am the non-prevailing party. If there is a settlement, I agree to pay half of the prorated fee. If I am the applicant and do not provide information for the IDRE to determine eligibility, the application will be rejected and I agree to pay a processing fee. If I am a provider and the dispute is for a surprise bill, I agree I shall not bill the patient except for any applicable copayment, coinsurance or deductible that would be owed if the patient had utilized a participating provider.

Provider or Health Plan Signature: _____

Print Name: _____

Date: _____