NEW YORK STATE INDEPENDENT DISPUTE RESOLUTION (IDR) PROVIDER AND INSURER APPLICATION FOR EMERGENCY SERVICES AND SURPRISE BILLS

A health care provider or HMO/insurer (health plan) may dispute a payment or charge for emergency services, including inpatient services after an emergency room visit, or for a surprise bill. Applicants must: (1) visit the Department of Financial Services (DFS) website at www.dfs.ny.gov to get a file number; (2) complete this application; and (3) send the application and the requested information to the assigned independent dispute resolution entity (IDRE). For help call (800) 342-3736 or email IDRquestions@dfs.ny.gov.

INFORMATION TO BE COMPLETED BY ALL APPLICANTS			
1. File Number Assigned by the DFS Website:			
2. Applicant is a (check one):	☐ Provider	☐ Health Plan	
3. Patient Information			
Name:			
Address:			
Health Plan ID Number:			
4. Health Plan Information			
Name:			
Address:			
Phone:		Fax:	
Email Address:			
5. Provider Information			
Name:			
Address:			
Phone:		Fax:	
Email Address:			
6. Dispute is (check one):	☐ **Emergency Services** including inpatient services after an emergency room visit (For dates of service before 1/1/22, 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 $714.64 or less.) ☐ **Surprise Bill** for Other Than Emergency Services		
7. Surprise bill certification form: (to be completed by provider if applicable)	☐ I received a surprise bill certification form signed by the patient and sent it to the health plan (required for all dates of service before 1/1/22 and for all services referred by an in-network doctor on and after 1/1/22). ☐ I signed a surprise bill certification form for in-network hospital or ambulatory surgical facility care and sent it to the health plan for dates of service on and after 1/1/22.		
8. Date(s) of Service:			
9. Place of Service:			

10. Provide the circumstances and complexity of the service including time and place, or submit when contacted by the IDRE if you want considered:	☐ Attached	☐ Not Attached
11. Provide individual patient characteristics, or submit when contacted by the IDRE if you want considered:	☐ Attached	☐ Not Attached
12. Identify the fee charged by the provider (attach a copy of the bill) or, for disputes involving a hospital, the hospital's final offer (amount IDRE should consider):		$
For disputes involving a hospital, attach an explanation of how the charges should be grouped and how the final offer was determined		
13. Identify the amount health plan paid as of date of application or, for disputes involving a hospital, the health plan's final offer (amount IDRE should consider):		$
For disputes involving a hospital, attach an explanation of how the charges were grouped and how the payment or final offer was determined.		

14. PROVIDER APPLICANTS COMPLETE THE FOLLOWING:

Complete and submit the following information with this application or when contacted by the IDRE, otherwise a decision will be made without the information.

a) Three (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.	☐ Attached	☐ Not Attached
b) The provider's usual charge for similar services when the provider does not participate with the health plan.	☐ Attached	☐ Not Attached
c) For physician providers, the physician's level of training, education and experience in relation to the service.	☐ Attached	☐ Not Attached
d) For hospital providers, the teaching status, scope of services, and case mix.	☐ Attached	☐ Not Attached

15. HEALTH PLAN APPLICANTS COMPLETE THE FOLLOWING:

a) Coverage Type:	☐ EPO	☐ HMO	☐ POS	☐ PPO	☐ Child Health Plus	☐ Essential Plan	☐ Medicaid Managed Care

b) Three (3) fees paid by the health plan as a final payment in the last 24 months to non-participating providers who are similarly qualified for the same service in the same region.	☐ Attached	☐ Not Attached
c) For physician services, the usual and customary cost for the service and the database from which this was derived.	☐ Attached	☐ Not Attached

ALL APPLICANTS COMPLETE THE FOLLOWING:

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, I agree I shall not bill the patient except for any copayment, coinsurance or deductible that would be owed if the patient had utilized a participating provider.

☐ For disputes involving a hospital, I attest that my entity's final offer was sent to the opposing party at least 15 days before the application was submitted to the IDRE. (Check box to attest if applicable)

Provider or Health Plan Signature:		
Print Name:		Date: