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

If you are uninsured, or you have health insurance coverage through your employer and your employer self-insures, you may dispute: (1) A bill for emergency services, including inpatient services after an emergency room visit; or (2) A surprise bill for physician services in a hospital or ambulatory surgical center if your provider did not give you all required information about your care. Complete this form and send it to the New York State Department of Financial Services, Attention: Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257. Call (800) 342-3736 or email IDRquestions@dfs.ny.gov for help or with questions.

You do not need to complete this form if you have coverage through an HMO or insurer subject to NY law (your health insurance ID card will say "fully insured") or for self-insured coverage that renews on and after January 1, 2022. If you receive a bill for emergency services or a surprise bill, contact your health plan, or your employer for self-insured coverage. You will only have to pay your in-network cost-sharing.

You do not need to complete this form if you received a good faith estimate from your provider about the cost of your treatment, and your provider bills you an amount that is at least $400 more than the good faith estimate. File a patient-provider dispute under the Federal No Surprises Act. You will have to pay a fee of no more than $25. For more information, visit CMS.gov/nosurprises.

COMPLETE THE FOLLOWING			
1. Patient Information			
Name:			
Address:			
Health Plan ID Number:		Phone:	
Email Address:			
2. Health Plan Information (If Applicable)			
Name:			
Address:			
Phone:		Fax:	
3. Provider Information			
Name:			
Address:			
Phone:		Fax:	
4. What type of bill are you disputing (check one):	☐ **Emergency Services** including inpatient services after an emergency room visit ☐ **Surprise Bill** for Non-Emergency Services		
5. Date(s) of Service:		**Place of Service:**	
6. Fee charged by the provider: (attach a copy of the bill)	$		
7. Amount your health plan paid (if any): Attach a copy of the notice or denial (if applicable).	$		
8. IDR Fee (Check one):	☐ I agree to pay the IDR fee up to $495 if the IDR determines my provider's fee is reasonable. If there is a settlement between me and the provider, I agree to pay half of the IDR fee. (If the IDR determines your provider's fee is not reasonable, your provider will pay the IDR fee.)		
	☐ Payment of the IDR fee is a financial hardship to me. My household income is $_____ and the number of people in my household is: _____ (Attach copies of your household's most recent pay stubs.)		

9. COMPLETE FOR SURPRISE BILLS ONLY

Complete this section if you received a surprise bill for non-emergency physician services in a hospital or ambulatory surgical center. (Check any information that you did not receive)

I attest that I have not received the information that I checked below:

My Physician did not tell me:

- ☐ **Health Plan Networks.** The health plans in which my physician is in-network.
- ☐ **Hospital Affiliations.** The hospitals with which my physician is connected.
- ☐ **Cost of Services Available.** That the amount my physician will bill me is available if I ask.
- ☐ **Hospital Services.** My physician scheduled another physician to treat me in the hospital and did not tell me the other physician's name, practice, address, phone number, and how to determine if the other physician is in my health plan's network.

My Hospital did not post on its website:

- ☐ **Charges.** A list of its charges or how to get the list.
- ☐ **Health Plan Networks.** The health plans in which the hospital is in-network.
- ☐ **Physicians Services in Hospital.** That services provided by physicians in the hospital are not included in the hospital's charges; that the physicians may or may not be in the same health plan networks as the hospital; and that I should ask the physician arranging my hospital services if the physician is in my health plan's network.
- ☐ **Physicians That Could Provide Services.** The name, address, and phone number of the physician groups the hospital has contracted with to provide services such as anesthesiology, pathology, or radiology and how to contact these groups to determine if they are in my health plan's network.
- ☐ **Physicians Employed by Hospital**. The name, address, and phone number of physicians employed by the hospital to treat patients and the health care plans in which they are in-network.

In registration or admission materials for non-emergency hospital services my Hospital did not:

- ☐ **Tell Me to Contact My Physician.** Tell me to check with the physician arranging my hospital services to determine: (1) the name, practice name, address, and phone number of any other physicians who will be asked by my physician to treat me; and (2) whether physicians who are employed or contracted by the hospital are expected to treat me.
- ☐ **In-Network Physicians.** Tell me how to find out whether physicians who are employees of the hospital (like anesthesiology, pathology, and radiology) are in my health plan's network.

10. PATIENT CONSENT to the release medical records for independent dispute resolution

By signing this application, I authorize my health plan and providers to release all relevant medical or treatment records related to the IDR, including any HIV-related information, mental health treatment information, or substance use disorder treatment information, to the IDR entity. I understand the IDR entity will use this information solely to make a decision on the dispute and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I acknowledge that the decision of the IDR is binding.

Signature of Patient (or patient's representative who can consent to the release of the patient's medical records. If a parent signs for a minor child, indicate the age of the child. If a guardian or executor signs, include proof of the appointment.):

Signature:		
Print Name:		Date: