PROVIDER AND HEALTH PLAN APPLICATION
NEW YORK STATE INDEPENDENT DISPUTE RESOLUTION FOR EMERGENCY SERVICES AND SURPRISE BILLS

A health care professional and hospital (provider) or HMO/insurer (health plan), including the New York State Empire Plan (Empire Plan) and Student Employee Health Plan (SEHP), may dispute a payment or charge for emergency services, including inpatient health care professional and hospital 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; (3) submit payment of the independent dispute resolution (IDR) entity's (IDRE's) full fee for reviewing the dispute; and (4) send the application to the assigned IDRE within three years of the health plan's initial payment. For help call 1-800-342-3736 or e-mail IDRquestions@dfs.ny.gov. Effective May 28, 2026, disputes involving Medicaid Managed Care coverage are no longer eligible for the NY IDR process. This applies regardless of whether the dispute is filed as a surprise bill or an emergency services dispute. If you submit an IDR dispute involving Medicaid Managed Care coverage, the dispute will be deemed ineligible, and you will be responsible for paying the applicable application processing fee.

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 Number: (_____)_____Fax Number: (_____)_____

Email Address: _____

5. **Provider Information**

Name:_____

Address:_____

Phone Number: (_____)_____Fax Number: (_____)_____

Email Address: _____

Rendering Provider NPI #: _____

6. **Dispute is (check one):**
   - ◯ **Emergency Services (including inpatient health care professional or hospital services after emergency room visit)**
   - ◯ **Surprise Bill**

7. **Surprise Bill Certification Form (to be completed by provider applicant if applicable).**
   - ◯ I received a surprise bill certification form signed by the patient and sent it to the health plan (required for all services referred by an in-network physician).
   - ◯ I signed a surprise bill certification form for in-network hospital or ambulatory surgical facility care and sent it to the health plan.

8. **Date(s) of Service**: _____
9. **Place of Service (Facility Name, Address, and Zip Code):**

_____

10. **Provide the circumstances and complexity of the service including time and place,** or submit when contacted by the IDRE if you want them considered: ◯ **Attached** ◯ **Not Attached**

11. **Provide individual patient characteristics,** or submit when contacted by the IDRE if you want them considered: ◯ **Attached** ◯ **Not Attached**

12. **Identify the fee charged by the provider (attach a copy of the bill and a copy of the claim form submitted to the health plan) or, for disputes involving a hospital that was previously in-network, the hospital's final offer (amount IDRE should consider):** _____
For disputes involving a hospital, attach an explanation of how the charges were grouped and how the final offer was determined.

13. **Identify the amount the health plan paid as of the date of application (attach a copy of the provider remittance advice (PRA)) or, for disputes involving a hospital that was previously in-network, 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 FOR ALL COVERAGE TYPES EXCEPT EMPIRE PLAN AND SEHP** and submit the 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) The health care professional'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. **PROVIDER APPLICANTS COMPLETE THE FOLLOWING FOR EMPIRE PLAN AND SEHP COVERAGE** and submit the information with this application or when contacted by the IDRE; otherwise, a decision will be made without the information.

   a) Coverage Type: ◯ **Empire Plan** ◯ **SEHP**

   b) Has a Federal IDR decision been issued for the same service in question? ◯ **Yes** ◯ **No**

      Is there a Federal IDR dispute for the same service in question that is currently pending a decision? ◯ **Yes** ◯ **No**
      If yes to either question under #15b, the claim is not eligible for the NY IDR process and you should not submit this application.

   c) The health care professional'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**

e) Were the health care services provided by a physician: (1) employed by a general hospital licensed under Public Health Law Article 28; (2) employed by the hospital's affiliated medical school; or (3) who is part of a group practice that is established as a captive professional services corporation whose shareholders are employees of such hospital? ◯ **Yes** ◯ **No**

If yes, submit documentation such as an employment contract or a letter from the hospital's medical board or governing body stating that the physician is an employee on the hospital's letterhead. Supporting documentation must be provided if the response to #15e is yes. ◯ **Attached** ◯ **Not Attached**

16. <u>HEALTH PLAN APPLICANTS OTHER THAN THE EMPIRE PLAN AND SEHP COMPLETE THE FOLLOWING</u> and submit the information with this application or when contacted by the IDRE; otherwise, a decision will be made without the fee information requested below.

a) Coverage Type: ◯ **EPO** ◯ **HMO** ◯ **POS** ◯ **PPO** ◯ **Child Health Plus** ◯ **Essential Plan**

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**

17. <u>EMPIRE PLAN AND SEHP APPLICANTS COMPLETE THE FOLLOWING:</u>

a) Coverage Type: ◯ **EMPIRE PLAN** ◯ **SEHP**

b) Has a Federal IDR decision been issued for the same service in question? ◯ **Yes** ◯ **No**

Is there a Federal IDR dispute for the same service in question that is currently pending a decision?
◯ **Yes** ◯ **No**
If yes to either question under #17b, the claim is not eligible for the NY IDR process.

c) 50% of the Allowed Amount (50th percentile of all allowed amounts for the health care service performed by participating providers in the same or similar specialty and provided in the same geographical area and the database from which this was derived).
◯ **Attached** ◯ **Not Attached**

d) 80% of the Allowed Amount (80th percentile of all allowed amounts for the health care service performed by participating providers in the same or similar specialty and provided in the same geographical area and the database from which this was derived).
◯ **Attached** ◯ **Not Attached**

18. <u>IMPORTANT INFORMATION</u>

The New York Financial Services Law requires that the applicant pay the IDR fee in full when submitting the IDR application and that the responding party pay the IDR fee in full when responding to a request for information from the IDRE. The IDRE will issue a refund of the dispute resolution process payment to the prevailing party within 30 days of rendering a determination on the dispute or to the applicant within 30 days of rejecting the dispute as ineligible. The IDRE will issue a refund minus an application processing fee for any dispute that the IDRE determines is ineligible. In cases where the IDRE issues a split decision or where a settlement occurs, the IDRE will issue a pro-rated refund to both parties. Providers are prohibited from billing the patient except for any copayment, coinsurance, or deductible that would be owed if the patient had used a participating provider.

19. <u>ALL APPLICANTS COMPLETE THE FOLLOWING:</u>

☐ I confirm that the full IDR fee has been paid.

☐ I understand that the IDRE's determination is binding.

20. ALL APPLICANTS COMPLETE THE FOLLOWING:

I attest that the information provided in this application is true and accurate to the best of my knowledge.

☐ For disputes involving a hospital that was previously in-network, I attest that a 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.)

☐ This form was filled out by a third-party representative of the applicant. (Check box if true.)

☐ **Opt-In to Electronic Communications**: By checking this box, I am agreeing to receive electronic communications from DFS and the IDRE concerning this IDR dispute.

☐ **Opt-Out of Electronic Communications**: By checking this box, I am indicating that I do not wish to receive electronic communications from DFS and the IDRE concerning this IDR dispute. Instead, I prefer to be contacted by the following method (pick one):

☐ Fax: (Fax Number)_____ _____

☐ Mail: (Mailing Address)_____

Authorized Representative's Signature: _____

Print Name: _____Date: _____

Title: _____ Employer's Name: _____