OMB Control Number: 0938-NEW
Expiration Date: XX/XX/XXXX

APPENDIX 9

Standard Notice: Selected Dispute Resolution (SDR) Entity Notification to Health Care Provider or Facility and Uninsured (or Self-Pay) Individual Confirming Receipt of Dispute Settlement and Action

(For use by SDR Entities beginning January 1, 2022)

Instructions

Under Section 2799B-7 of the Public Health Service Act and its implementing regulations, the U.S. Department of Health & Human Services (HHS) is required to establish a patient-provider dispute resolution process where a Selected Dispute Resolution (SDR) entity can resolve a payment dispute between individuals who are not enrolled in a group health plan, or group or individual health insurance coverage, or a Federal health care program, or a Federal Employees Health Benefits (FEHB) program health benefits plan (uninsured individuals), or who are not seeking to file a claim with their group health plan, health insurance coverage, or FEHB health benefits plan (self-pay individuals), and health care provider, facility, or provider of air ambulance services by determining the amount such individual must pay to their health care provider, facility, or provider of air ambulance services. Under federal criteria, SDR entities will review initiation notices to determine that an uninsured (or self-pay) individual is eligible to dispute a bill.

Any point after the dispute resolution process has been initiated but before the date on which a determination is made by the SDR entity, the parties can settle the payment amount through either an offer of financial assistance or an offer to accept a lower amount, or an agreement by the uninsured (or self-pay) individual to pay the billed charges in full. In the event that the parties agree to settle on a payment amount, the provider or facility should notify the SDR entity through the federal IDR Portal, electronically, or in paper form, as soon as possible, but no later than 3 business days after the date of the agreement.

This notice is for use by the SDR entity to notify the health care provider or facility and uninsured (or self-pay) individual that the settlement agreement has been received and the dispute is closed or the SDR entity requires additional information from the parties.

HHS has developed this standard notice so that providers or facilities and uninsured (or self-pay) individuals can confirm that the SDR entity has received their settlement agreement and has either closed their case or requires more information. To use this standard notice the SDR entity must fill in the blanks with the appropriate information.

NOTE: The information provided in these instructions is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. Readers should refer to the applicable statutes, regulations, and other interpretive materials for complete and current information, including the HHS interim final rules (IFR) titled *Requirements Related to Surprise Billing; Part II*, published on October 7, 2022.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 1210-0169. The time required to complete this information collection is estimated to average 1.3 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Selected Dispute Resolution (SDR) Entity Notification to Health Care Provider or Facility and Uninsured (or Self-Pay) Individual Confirming Receipt of Dispute Settlement and Corresponding Action

Date

Uninsured (or self-pay) individual or Authorized Representative Name
Uninsured (or self-pay) individual or Authorized Representative Address
Uninsured (or self-pay) individual or Authorized Representative City, State, Zip

Health care Provider or Facility Name
Health care Provider or Facility Address
Health care Provider or Facility Name City, State, Zip

RE: Patient-provider dispute resolution process settlement decision re:
Reference Number:XXXXXXXX

[Uninsured (or self-pay) individual or Authorized Representative Name], [Health care Provider or Facility Name]

We have received and reviewed the Settlement information for [Reference Number: XXXXXXXX] submitted by [Health Care Provider or Facility Name].

- ☐ [Check this box if all information is included.] The Settlement agreement meets all requirements. The [uninsured (or self-pay) individual (or authorized representative) name] has agreed to pay [enter amount uninsured (or self-pay) individual has agreed to pay] for [disputed item or service]. This dispute is considered settled and closed and the agreed upon payment amount shall apply.

This decision is binding, unless there are claims of fraud or a misrepresentation of facts presented to us, in which case you may have the right to other legal remedies. Also, [health care provider or facility name] may provide financial assistance or agree to an offer for a lower payment amount, or [Uninsured (or self-pay) individual name] may agree to pay the billed charges in full, or may agree with [health care provider or facility name] on a different payment amount. For more information, see www.cms.gov/nosurprises/consumers.

- ☐ [Check this box if information is missing.] The Settlement agreement is missing information. [Health care Provider or Facility Name] should provide the missing item(s) identified below:

    - ☐ The agreed upon settlement amount the uninsured (or self-pay) individual will pay

- ☐ The date the settlement was reached
- ☐ Documentation demonstrating that the provider or facility and uninsured (or self-pay) individual have agreed to the settlement
- ☐ Demonstration that a reduction of at least half the amount of the administrative fee has been applied to the patient's final payment amount
- ☐ Other, explain:

Sincerely,

[SDR Entity Name], Selected Dispute Resolution Entity

[Company email]

[Company phone]

[Company Fax #]

PRIVACY ACT STATEMENT: CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.