PATIENT APPLICATION
NEW YORK STATE 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 physician services in a hospital; or (2) a surprise bill for non-emergency 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 NYS Department of Financial Services, Consumer Assistance Unit/IDR Process, One Commerce Plaza, Albany, NY 12257. For help call 1-800-342-3736 or e-mail IDRquestions@dfs.ny.gov.

You do not need to complete this form if you have coverage through an HMO or insurer subject to NY law (coverage that is not self-insured). If you receive a surprise bill, you can sign an assignment of benefits form to permit your HMO or insurer to pay your provider directly. Your HMO or insurer will dispute the bill for you and you will only have to pay your in-network cost-sharing. If you receive a bill for emergency services, contact your HMO or insurer. You will only have to pay your in-network cost-sharing for emergency services.

COMPLETE THE FOLLOWING

1. **Patient Name:** _____
2. **Patient Address:** _____
3. **Patient Phone Number: (____)**_____ **E-mail Address:** _____
4. **Health Plan (if applicable):**_____
5. **Health Plan Address (if applicable):**_____
6. **Health Plan Phone Number: (_____)**_____**Fax Number: (_____)**_____
7. **Provider Name:** _____
8. **Provider Address:** _____
9. **Provider Phone Number: (_____)**_____**Fax Number: (_____)**_____
10. **What type of bill are you disputing?** (Please check one.)
    [ ] Emergency Services [ ] Surprise Bill for Other than Emergency Services
11. **Date(s) of Service**: _____
12. **Time and Place of Service:** _____
13. **The fee charged by the provider (include a copy of the bill):** _____
14. **If applicable, the amount your health plan paid (include a copy of the plan notice or denial):**_____
15. **IDR Fee: Check one if you are uninsured or you are covered under employer self-insured coverage.**

    [ ] I agree to pay the IDR fee up to $325 if the IDR determines my physician's fee is reasonable. If there is a settlement between me and my physician I agree to pay half of the IDR fee. (If the IDR determines your physician's fee is not reasonable, your physician 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: _____
    (Fill in the above information and attach copies of your household's most recent pay stubs.)

16. **To be completed if you are uninsured or covered under employer self-insured coverage and receive a surprise bill for non-emergency physician services in a hospital or ambulatory surgical center.** I attest that I have not received the information from my physician or hospital that I checked below. (Please check any information that you did not receive.)

    My Physician did not tell me:
    [ ] Health Plan Participation. The health plans in which my physician participates.
    [ ] Hospital Affiliations. The hospitals with which my physician is affiliated.
    [ ] Cost of Services Available. That the amount my physician will bill me is available if I ask.
    [ ] Cost of Services Requested. I asked my physician how much my physician will bill me for services and my physician did not tell me.
    [ ] 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, telephone number and how to determine if the other physician participates with my health plan.

    My Hospital did not post on its website:
    [ ] Charges. A list of its charges or how to get the list.
    [ ] Health Plan Participation. The health plans in which the hospital is a participating provider.
    [ ] Physicians Services in Hospital. That services provided by physicians in the hospital are not included in the hospital's charges; that physicians who provide services in the hospital may or may not participate with the same health plans 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 telephone 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 participate with my health plan.
    [ ] Physicians Employed By Hospital. The name, address, and telephone number of physicians employed by the hospital to treat patients and the health care plans in which they participate.

    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 telephone number of any other physicians who will be arranged by my physician to treat me; and (2) whether physicians who are employed or contracted by the hospital are expected to treat me.
    [ ] Participating Physicians. Tell me how to find out whether physicians who are employees of the hospital (such as for anesthesiology, pathology and radiology) participate with my health plan.

17. **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 the 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.)

Print Name: _____

Date: _____