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

A provider or HMO/insurer (health plan) may dispute a payment or charge for emergency services or a surprise bill. Applicants must: (1) visit the Department of Financial Services (DFS) website at www.dfs.ny.gov to receive a file number; (2) complete this application; and (3) send it to the assigned independent dispute resolution entity. For help call 1-800-342-3736 or e-mail IDRquestions@dfs.ny.gov.

TO BE COMPLETED BY ALL APPLICANTS

1. **File Number assigned by the DFS website:** _____
2. **Applicant Name:**_____
   [ ] Provider [ ] Health plan (Please check one.)
3. **Patient Name:** _____
4. **Patient Address:** _____
   _____
5. **Patient's Health Plan ID Number:** _____
6. **Health Plan:** _____
7. **Health Plan Address:** _____
8. **Phone Number: (_____)**_____**Fax Number: (_____)**_____
9. **Provider Name:** _____
10. **Provider Address:** _____
11. **Phone Number: (_____)**_____**Fax Number: (_____)**_____
12. **Email Address:** _____
13. **What type of payment or charge are you disputing?** (Please check one.)
    ☐ **Emergency Services** ☐ **Surprise Bill for Other than Emergency Services**
14. **Date(s) of Service**: _____
15. **Place of Service:** _____
16. **The fee charged by the provider (and include a copy of the bill):** _____
17. **The fee paid to the provider:** _____
18. **The circumstances and complexity of the service including time and place, or submit when contacted by the IDRE if you want considered:** _____
    _____
19. **Individual patient characteristics, or submit when contacted by the IDRE if you want considered:**

20. **Independent Dispute Resolution Eligibility:**

    a) **For Emergency Services**: 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 $693.66 (for 2020 and adjusted annually for inflation rates) or less.
    ☐ **Yes eligible** ☐ **Not eligible** ☐ **Don't know (Please check one.)**

    b) **For Surprise Bills:** Have you obtained an assignment of benefits signed by the patient and did you send it to the provider/health plan?
    ☐ **Yes** ☐ **No (Please check one.) (If yes, please attach.)**

21. **Provider applicants, complete the following or submit when contacted by the IDRE:**

    a) **Include a representative sample of at least 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.**

    _____

    b) **The provider's level of training, education and experience in relation to the service.**

    _____

    c) **The provider's usual charge for similar services when the provider does not participate with the health plan.**

    _____

22. **Health plan applicants, complete the following or submit when contacted by the IDRE:**

    a) **A representative sample of at least 3 fees paid by the health plan as a final payment in the last 24 months to non-participating physicians who are similarly qualified for the same service in the same region.**

    _____

    b) **The usual and customary cost for the service and the database from which this was derived.**

    _____

23. **To be completed by all applicants.**
    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 and the dispute is for a surprise bill, I agree I shall not bill the patient except for any applicable copayment, coinsurance or deductible that would be owed if the patient had utilized a participating provider.

Provider or Health Plan Signature: _____

Print Name: _____

Date: _____