OMB Control Number: 0938-XXXX
Expiration Date: xx/xx/xxxx

APPENDIX 10

Standard Notice: Patient and Provider Settle on a Payment Amount After Initiating Patient-Provider Dispute Resolution

(For use by health care providers beginning January 1, 2022)

Instructions

Under Section 2799B-7 of the Public Health Service Act, the U.S. Department of Health & Human Services (HHS) is required to establish a patient-provider dispute resolution process where Selected Dispute Resolution (SDR) entity can resolve a payment dispute between individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals), and health care provider or health care facility by determining the amount such individual is to pay to such health care provider or health care facility for the items or services subject to patient-provider dispute resolution process.

This notice is for use by the health care provider to notify the SDR entity and HHS in the event that **all** parties agree to settle on a payment amount after the patient-provider dispute resolution process has been initiated and **prior to the SDR entity making a determination**. While the determination by the SDR entity is pending, the two (2) parties to the patient-provider dispute resolution process (the uninsured (or self-pay) individual and the health care provider or health care facility) may agree to resolve the dispute by settling on a payment amount. When the parties settle on the amount, federal standards require the provider to notify the SDR entity and HHS no later than three (3) business days after the date of the agreement.

HHS has developed this model notice so that providers or facilities may use it to inform SDR entities that a settlement has been reached between an uninsured (or self-pay) individual and the health care provider or facility. To use this model notice, the provider or facility must fill in the blanks with the appropriate information. HHS considers use of the model notice to be good faith compliance.

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.

Providers and facilities should not include these instructions with the documents they give to the selected SDR entities.

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 0938-XXXX. The time required to

complete this information collection is estimated to average XX 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.

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Health Care Provider Notice of Payment Settlement to Selected Dispute Resolution Entity

A health care provider or facility must complete this form when an uninsured (or self-pay) individual or the individual's authorized representative have resolved a payment dispute outside of the dispute resolution process.

Federal standards require health care providers and facilities to notify the Selected Dispute Resolution (SDR) entity, no later than 3 business days after the date of the settlement.

Please complete the information about the payment agreement.
Today's date: _____/_____/_____
SDR Entity Name:
Reference Number:
Provider or Facility Name:
Agreed Payment Amount
Date when the new payment agreement was reached: _____/_____/_____
Select one: [ ] We agreed to a new payment amount. The final payment amount for the patient is: $ [ ] We agreed to provide financial assistance. The final payment amount for the patient is: $

Patient Information		
Patient Name: First Name	Middle Name	Last Name
(optional) Authorized Representative Name:		
Health Care Provider Information		
Health Care Provider Name		
Hospital or Group Name		
Street		
City	State	ZIP
Email	Phone	
I have included with this form (check one)**:**		
[ ] Documentation signed by the patient and agreeing to the new payment amount [ ] Documentation from the patient agreeing to the new payment in the form of an email, letter, or fax		
[ ] I acknowledge that I am sending this for this form to the SDR entity, the patient or authorized representative, and the U.S. Department of Health and Human Services (HHS) by uploading it to www.cms.gov/nosurprises		

Once you submit this form, the SDR entity will confirm receipt of documentation and notify the health care provider of the reduced SDR entity fee [owed by/ that will be refunded] by [call/email/ www.cms.gov/nosurprises].