APPENDIX 4

Patient-Provider Dispute Resolution Form

Find out if you qualify for the dispute resolution process

This form is only for people who do **not** have health insurance or who decided not to use insurance for their medical care.		
Did your health care provider give you a Good Faith Estimate for the item or service?	Yes ☐	No ☐
Is the bill for your health care provider at least $400 more than the Good Faith Estimate?	Yes ☐	No ☐
Is the **date on the top of the bill** within the last 120 calendar days (about 4 months)?	Yes ☐	No ☐

If you answered **NO** to any of these questions:

- You do not qualify for the dispute resolution process. Please contact your health care provider to negotiate your bill and ask for financial assistance.
- If you think you should have been given a Good Faith Estimate or have other questions, please visit www.cms.gov/nosurprises or call 1-800-985-3059.

If you answered **YES** to **ALL** of these questions:
You qualify for the dispute resolution process. Please complete the rest of this form.

Note: While the dispute resolution process is happening, you can still ask your health care provider for a lower bill.

Patient name (and Authorized Representative name, if needed)		
Patient First Name	Middle Name	Last Name
(Optional) **If you are filling out this form for the patient, please print your name:** [ ] Check this box if you are an Authorized Representative and should be contacted instead of the patient. Write **your** information in the “mailing address and phone number” section. Note: This is common for patients under age 18 or patients who need help completing medical forms.		

Mailing Address and Phone Number		
Street or PO Box	**Apartment**	
City	State	ZIP
Phone		

Details about the medical item or service you want to dispute		
The State where the patient received the item or service:		
The date when the patient received the item or service: Month	Day	Year

Write a short description of the item or service you want to dispute. (For example, “knee replacement” or “cervical cancer screening”)
I have included with this form:
[   ] A copy of the bill from my health care provider that I want to dispute
[   ] A copy of the Good Faith Estimate for the item or service that I want to dispute
Contact information for the health care provider that provided the item or performed the service. This should be on your Good Faith Estimate.
Health Care Provider Name **Wellstar Health System**
Hospital, Facility, or Group Name
Street **P.O. Box 742625**
City / State / ZIP **Atlanta** / **GA** / **30374-2625**
Email **wellstarcomplaintescalation@wellstar.org** / Phone **470-245-9998**

Read and sign

- I agree to let my health care provider to release all relevant medical or treatment records related to this dispute, to a Selected Dispute Resolution (SDR) entity and selected by the U.S. Department of Health and Human Services (HHS). I understand the SDR entity will only use this information to make a decision on this dispute. My information will be kept confidential and not released to anyone else. If this information is still needed after 1 year, I will be asked to release my information again.
- I agree to pay a $25 fee for the dispute process.
- When the SDR entity makes the decision about the price for these medical items or services, I agree to pay the decided amount.

[ ] Check here to agree

Signature	Date

Print Name

How to send this form
Make sure you have included: • A copy of the **bill** from your health care provider or facility that you want to dispute • A copy of the **Good Faith Estimate** for the item or service that you want to dispute You can send this form and documents: • **Online** www.cms.gov/nosurprises or through the federal IDR portal • **By mail** C2C Innovative Solutions Inc, Patient-Provider Dispute Resolution P.O. Box 45105 Jacksonville, FL, 32232-5105 For additional help call **1-800-985-3059.** When HHS receives this form, they will send you a link where you can pay the fee to start the dispute process.

Keep a copy or take pictures of this completed form. You may need it later.

For more information about your right under federal law to dispute medical bills, visit: www.cms.gov/nosurprises