

Date of Notice: \_\_\_\_\_

You are receiving this notice because \_\_\_\_\_,  
Enter name of party initiating negotiations

a(n) \_\_\_\_\_  
Enter one: group health plan, health insurance issuer, federal employee health benefits (FEHB) carrier, healthcare provider, healthcare facility, or provider of air ambulance services

is disputing the out-of-network rate for \_\_\_\_\_.  
Insert appropriate descriptor of the item(s) or service(s)

The No Surprises Act provides a federal independent dispute resolution (IDR) process that group health plans; health insurance issuers of group and individual health insurance coverage; FEHB carriers; and out-of-network or non-participating healthcare providers, facilities, and providers of air ambulance services may use to determine the out-of-network rate for certain services following the end of an open negotiation period.

The federal IDR process is available only for select services, such as out-of-network emergency services, certain services provided by out-of-network providers at an in-network facility, or air ambulance services. The federal IDR process is available only if a state All-Payer Model Agreement or specified state law does not apply.

## What Is an Open Negotiation Period?

The open negotiation period may last up to 30 business days. During this time, the negotiating parties will determine an agreeable amount for the total out-of-network rate (including any cost sharing) for an item or service furnished by a non-participating healthcare provider, facility, or air ambulance provider to a participant, beneficiary, or enrollee in a group health plan, group or individual health insurance policy, or FEHB carrier for which a payment is required by the plan or coverage.

## What Happens at the End of the Open Negotiation Period?

If we have not agreed upon a payment amount by the end of the open negotiation period on \_\_\_\_\_,  
Enter date occurring 30 business days after the Date of Notice above

either party may initiate the federal IDR process by \_\_\_\_\_ under which a certified IDR entity will select  
Enter date occurring four business days after the end of the open negotiation period

the payment amount for the item(s) and/or service(s).

Initiating the federal IDR process does not prohibit us from agreeing on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount.

For more information on the federal IDR process, and to obtain the notice to initiate the federal IDR process, visit [cms.gov/nosurprises](https://www.cms.gov/nosurprises).

### Attestation

I attest that I am authorized to submit this request and that the information on this form is accurate and complete to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please complete and sign the *Supplemental Open Negotiation Request Form*. Completed forms may be emailed to [QualChoiceIDRRequests@qualchoice.com](mailto:QualChoiceIDRRequests@qualchoice.com).

Or, forms may be mailed or faxed to the following:

QualChoice Health Insurance  
P.O. Box 25610  
Little Rock, AR 72221

Fax: 501-707-6811

This form is for non-participating providers to initiate the negotiation process for initial claim payment under the No Surprises Act.

Non-participating providers may dispute the initial amount paid on a claim for emergency, air ambulance, or other professional services in the scope of the No Surprises Act. To initiate the 30-day negotiation process provided under the No Surprises Act, providers should complete and email this form to [QualChoiceIDRRequests@qualchoice.com](mailto:QualChoiceIDRRequests@qualchoice.com).

The form may also be mailed or faxed to the following:

QualChoice Health Insurance P.O. Box 25610 Little Rock, AR 72221	Fax: 501-707-6811
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*Note: The negotiation period will not begin until QualChoice has received the completed request form(s) and remit statement(s).*

### Contact for Negotiation

Name	
Facility, Group, or Provider Representing	
Phone	Email
Best Time of Day for Virtual Meeting • Option 1	Best Time of Day for Virtual Meeting • Option 2

### Provider Information

Name of Facility Where Services Were Rendered			
Place of Service Address	City	State	ZIP
Taxpayer Identification Number (TIN)	National Provider Identifier (NPI)		

1	Description of Item(s) and/or Service(s)	Date Provided	Service Code(s) (CPT®, DRG, or HCPCS)	Initial Payment Amount <i>(if no initial payment was made, write N/A)</i> \$ _____
		QualChoice Claim Number	Member Number	Amount Requested for Out-of-Network Rate <i>(including any cost share)</i> \$ _____
2	Description of Item(s) and/or Service(s)	Date Provided	Service Code(s) (CPT®, DRG, or HCPCS)	Initial Payment Amount <i>(if no initial payment was made, write N/A)</i> \$ _____
		QualChoice Claim Number	Member Number	Amount Requested for Out-of-Network Rate <i>(including any cost share)</i> \$ _____
3	Description of Item(s) and/or Service(s)	Date Provided	Service Code(s) (CPT®, DRG, or HCPCS)	Initial Payment Amount <i>(if no initial payment was made, write N/A)</i> \$ _____
		QualChoice Claim Number	Member Number	Amount Requested for Out-of-Network Rate <i>(including any cost share)</i> \$ _____
4	Description of Item(s) and/or Service(s)	Date Provided	Service Code(s) (CPT®, DRG, or HCPCS)	Initial Payment Amount <i>(if no initial payment was made, write N/A)</i> \$ _____
		QualChoice Claim Number	Member Number	Amount Requested for Out-of-Network Rate <i>(including any cost share)</i> \$ _____
5	Description of Item(s) and/or Service(s)	Date Provided	Service Code(s) (CPT®, DRG, or HCPCS)	Initial Payment Amount <i>(if no initial payment was made, write N/A)</i> \$ _____
		QualChoice Claim Number	Member Number	Amount Requested for Out-of-Network Rate <i>(including any cost share)</i> \$ _____
6	Description of Item(s) and/or Service(s)	Date Provided	Service Code(s) (CPT®, DRG, or HCPCS)	Initial Payment Amount <i>(if no initial payment was made, write N/A)</i> \$ _____
		QualChoice Claim Number	Member Number	Amount Requested for Out-of-Network Rate <i>(including any cost share)</i> \$ _____

## Attestation

I attest that I am authorized to submit this request and that the information on this form is accurate and complete to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date