

New York State Out-of-Network Surprise Medical Bill

You may not be responsible for a surprise bill for out-of-network services

A “Surprise Bill” is when you have insurance coverage issued in the State of NY:

Hospital or surgical centers: You are a patient at a participating hospital or ambulatory surgical center and you receive services for which:

- A network doctor was not available
- An out-of-network doctor provided without your knowledge
- Unforeseen medical circumstances arose at the time the health care services were provided.

It will not be a surprise bill if you chose to receive services from an out-of-network doctor instead of from an available network doctor.

Referrals: Your network doctor did not ask your consent to refer you to an out-of-network doctor, lab or other health care provider, and did not tell you it would result in costs not covered by your health plan.

An independent dispute resolution entity (IDRE) can determine if you need to pay the bill. You, the plan or your doctor may request an independent dispute resolution (IDR) for surprise bills and referrals. Use the form on the next page to submit your request. You do not have to pay the bill in order to be eligible to submit the dispute for review to an IDRE.

Dispute resolution process

1. **Submit your request for independent review:**
Complete the form on the next page. You can call Customer Service if you need help completing the form. The phone number is on your ID card. You may mail the form to us at:

Wellfleet

PO Box 15369
Springfield, MA 01115-5369

Or send the form electronically to:
customerservice@wellfleetinsurance.com

2. **An independent dispute resolution entity (IDRE) approved by the State of New York will screen your request for eligibility.**

If the IDRE needs more information, it will contact the health plan or health care provider. If the requested information is not submitted within three business days, or if the application is not eligible, the IDRE will reject the application.

3. **The IDRE will send a letter to the person who initiated the request (you, the doctor, CHP)**

The letter will include:

- A request for the information needed to complete the review
- A request for any additional information that may be available to support the request
- Where to send the information

4. **You must submit any requested information within five business days of receiving the letter**

If IDRE receives a partial response or no response, the dispute will be decided based on the available information. You cannot ask for reconsideration by submitting additional information after the decision is made.

5. **The IDRE will make a determination within 30 days of receiving the request**

If IDRE feels either the provider’s bill or the health plan’s coverage policy is extreme, it may direct them to attempt a good faith negotiation for settlement. They will have up to ten business days for this negotiation.

A neutral and impartial reviewer with training and experience in health care billing, reimbursement, and usual and customary charges will review the dispute. The IDRE will forward copies of its decision to the health plan, the physician, superintendent, and as applicable, the nonparticipating referred health care provider and the patient, within two business days of making the decision.

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the **Department of Financial Services at 1-800-342-3736**.

A surprise bill is when:

1. You received services from a nonparticipating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a nonparticipating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a nonparticipating physician instead of from an available participating physician; OR
2. You were referred by a participating physician to a nonparticipating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a nonparticipating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a nonparticipating laboratory pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent/s) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent/s received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent/s used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Your Name: _____

Your Address: _____

Insurer Name: _____

Your Insurance ID No: _____

Provider Name: _____ Provider Phone Number: _____

Provider Address: _____

Date of Service: _____

Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(Signature of patient)

(Date of signature)