ARIZONA DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS

REQUEST FORM (SOONBDR)

HEALTH CARE APPEALS ☎ 602-364-2399 | https://difi.az.gov/soonbdr

Before you submit a request for surprise billing dispute resolution…

It is important that you know the following:

1. Only submit a request for dispute resolution if eligible. Your health insurer can help you determine eligibility and can provide information you need to complete the request form. Arizona Revised Statutes ("ARS") §§ 20-3111 through 20-3119 define which healthcare bills are eligible for the dispute resolution process. By law, the dispute resolution process **does not apply to**:
   - A health care service the enrollee received before January 1, 2019;
   - A health care service provided more than a year before the enrollee submits a request for arbitration (extended by any time the bill was the subject of a health care appeal);
   - A bill that is $999.99 or less after deducting amounts paid by the health insurer and the enrollee's copay, coinsurance, and deductible;
   - Limited benefit coverage;
   - Health and accident coverage for state employees and their dependents;
   - Self-funded or self-insured employee benefit plans preempted by the Employee Retirement Income Security Act of 1974 (a.k.a. ERISA) - your insurance card may show "ASO" or "Administrative Services Only" if you are covered under a self-funded plan;
   - Health plans that exclude out-of-network coverage unless otherwise required by law;
   - Health care services that are not covered by the health plan;
   - Health care services not provided from a hospital, outpatient surgical center, laboratory, diagnostic imaging center or urgent care center that has a contract with the health insurer ("network facility");
   - Provider or health facility charges that an individual agreed to directly pay rather than using the health plan;
   - Provider or health facility charges for which the enrollee signed a disclosure notice on which the enrollee was provided information required by Arizona law, thereby resulting in the enrollee waiving rights to arbitration if the amount of the provider's bill was no greater than the estimated total cost that the provider included on the disclosure notice;
   - A health care service that is the subject of a health care appeal that has not been decided;
   - A health care bill or health care service that is the subject of a legal action that the enrollee initiated;
   - A bill that was previously settled or decided through the dispute resolution (arbitration) process.
2. Only submit a request for dispute resolution on paper if you cannot submit your request online. You can access the secure, online Surprise Out-of-network Billing Dispute Resolution (SOONBDR) system from https://difi.az.gov/soonbdr
3. While information you submit will generally be treated as confidential, the information may be shared with the healthcare provider who billed you and the healthcare provider's authorized representative and billing company, with your insurance company and with an arbitrator selected to make decisions about your request. When sending sensitive information by mail, you should consider using a method that will track the delivery.
4. You will need to submit clear photocopies of the following documents listed on the last page of the request form.
   - **ESSENTIAL**: A copy of the bill(s) and statement(s) you received from your provider that are part of the surprise billing;
   - **ESSENTIAL**: A copy of both sides of your health insurance card (showing the name of the insurance company, your member number, plan ID number, and other information)
   - **ESSENTIAL**: A copy of the "Explanation of Benefits" that you received from your insurance company (showing the amount the healthcare provider billed and the amount the health insurance company has paid)
   - **HELPFUL**: A copy of any payment(s) you made to your provider for copayments, coinsurance, deductibles or any other part of the provider's invoice;
   - **HELPFUL**: A copy of each notice or document you or someone on your behalf sent to or received from the provider or insurer that pertains to the healthcare services or surprise bill you received.

REQUEST FORM (SOONBDR)

You must be 18 years or older to complete this form.

Enrollee Information

Enter information about the person who received the invoice for the healthcare services (the "enrollee")

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (JR./SR./ETC.)
EMAIL ADDRESS			AREA CODE AND PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP CODE

Insurance Coverage Information

NAME OF INSURANCE COMPANY		
MEMBER ID NO.	GROUP NO.	

Patient Information

Enter information about the patient who received the healthcare services that resulted in the surprise bill.

Same as Enrollee? ☐ Yes ☐ No

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (JR./SR./ETC.)
DATE OF BIRTH MM/DD/YYYY	RELATIONSHIP TO ENROLLEE		

Healthcare Provider Details

Enter all the information you know about the healthcare provider that provided the healthcare services that are presented on the surprise bill.

NAME OF HEALTHCARE PROVIDER	BUSINESS NAME (IF PART OF THE ADDRESS)		
BILLING ADDRESS ON BILL	CITY	STATE	ZIP CODE
EMAIL ADDRESS		AREA CODE AND PHONE NUMBER	

Continued…

Bill Details

Line 1: Date the healthcare services were provided (mm/dd/yyyy). Must be on or after 01/01/2019 to qualify for the dispute resolution process	MM/DD/YYYY
Line 2: Amount that the healthcare provider billed the enrollee for the healthcare service ***after subtracting the amount paid by the health insurer***	$
Line 3: Required copayment (the fixed amount your health insurance plan requires you to pay when you receive this type of out-of-network healthcare service)	$
Line 4: Required coinsurance (your portion of the amount that your health insurance plan has designated is the allowed amount to be paid to the healthcare provider for this type of out-of-network healthcare service – *for example, if the allowed amount were $10,000.00 and your health plan requires you to pay 20% of the allowed amount, you would enter $2,000.00*)	$
Line 5: Deductible remaining before this bill for healthcare services (the amount you must pay for healthcare services before your health insurance plan will begin to pay healthcare expenses – the amount of deductible that you need to pay should be reflected on the Explanation of Benefits ("EOB") that your health insurance plan provided you after your received healthcare services	$
Surprise bill amount: Line 2 minus Line 3 minus Line 4 minus Line 5. This is the amount that you are entitled to dispute. This amount must be at least $1,000.00 for you to be eligible for the dispute resolution process.....	**$**

Additional Eligibility Questions

	YES	NO
1. Prior to receiving the healthcare services, did the enrollee sign a notice disclosing the name of the healthcare provider, the fact that the provider was not a contracted provider, and the estimated cost to be billed by the provider or the provider's representative? If "Yes", ***include a copy of the notice with this request***.	☐	☐
a. Was the amount actually billed by the healthcare provider more than the estimated total cost provided on the notice (even if only by a penny)?	☐	☐
2. Did the insurance company deny a claim for the healthcare services that are on the surprise bill (e.g. the insurance company says the healthcare service is not covered under the health plan)?	☐	☐
3. Did you institute a lawsuit or other legal proceeding against the insurance company or health care provider because of the surprise billing or relating to the healthcare service?	☐	☐
4. Did the enrollee pay the provider the amount that the health plan requires an enrollee to pay for healthcare services, including copayment, coinsurance and deductible?	☐	☐
a. Does the enrollee have a written agreement with the provider to pay the copayment, coinsurance and deductible? If "Yes", ***include a copy of that agreement with your request***.	☐	☐
5. Were the healthcare services provided at a facility that is "in-network" (contracted with your health insurance plan)?	☐	☐
6. Were the services "emergency services"?	☐	☐
7. Were the services provided after the patient was formally admitted to a network facility for additional assessment or treatment following an emergency visit?	☐	☐

Continued…

Authorized Representative Information

For the purposes of the surprise out-of-network billing dispute resolution request, an "**authorized representative**" is a person appointed to act on behalf of the enrollee. Both the enrollee and the authorized representative will receive notifications about the status of the request, and either the enrollee or the authorized representative must fulfill requirements for the request to remain valid. If neither the enrollee nor the authorized representative timely fulfill a requirement, the request for dispute resolution may be denied and the enrollee's right to dispute resolution may be forfeited.

Who is completing this form? ☐ **Enrollee** ☐ **Authorized Representative**

ENROLEE: Do you wish to appoint an individual to serve as your authorized representative concerning your request for dispute resolution?
If "No", *leave the following section blank and skip to the next section*.
If "Yes," *complete and sign this section* ..... ☐ Yes ☐ No

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (JR./SR./ETC.)
EMAIL ADDRESS			AREA CODE AND PHONE NUMBER
MAILING ADDRESS	CITY	STATE	ZIP CODE

SIGNATURE

_____ _____
SIGNATURE DATE

_____
PRINTED NAME (if not applying digital signature)

Continued…

Dispute Resolution Request Checklist

Include with this form clear photocopies of the following documents OR attach ".pdf" files to your online-submitted complaint:

- ☐ ESSENTIAL: A copy of the bill(s)/statement(s) you received from your healthcare provider that are part of the surprise billing.
- ☐ ESSENTIAL: A copy of *both* sides of your health insurance card showing the name of the insurance company, your member number, plan ID number and other information.
- ☐ ESSENTIAL: A copy of the "Explanation of Benefits" (or "EOB") document that you received from your insurance company, which shows the amount the healthcare provider billed and the amount the health insurance company has paid.
- ☐ HELPFUL: A copy of any payment(s) you made to the healthcare provider for copayments, coinsurance, deductibles or any other part of the provider's invoice.
- ☐ HELPFUL: A copy of each notice, email, letter or other document you or someone on your behalf sent to or received from the healthcare provider or health insurer that pertains to the healthcare services or surprise bill you received.
- ☐ **ESSENTIAL IF YOU ARE THE AUTHORIZED REPRESENTATIVE**: If you completed this form on behalf of the enrollee, you must include evidence that you have the legal authority to act on the enrollee's behalf, such as a copy of a court appointment or contract with the enrollee.

ATTESTATION

By signing below, you certify and attest that all information provided in and as part of this request for dispute resolution is true and correct to the best of your knowledge and belief.

Person Completing this Form/Attestation: ☐ **Enrollee**

☐ **Authorized Representative**

_____ _____

SIGNATURE DATE

_____

PRINTED NAME (if not applying digital signature)